Andrea Peterson, LMFT #85722
2378 Maritime Dr. Suite 100
Elk Grove, CA 95758
(916)849-1273

Stacey Thao, IMF #69834
2378 Maritime Dr. Suite 100
Elk Grove, CA 95758
(916)807-0571

Authorization to use and disclose protected health information

I, _____ authorize ANDREA PETERSON, LMFT, or STACEY THAO, IMFT, to release and exchange information obtained in the course of my evaluation and treatment to (insurance company, doctor, school. etc)_____

_____

The disclosure of the information is required for the following purpose:

_____Managed Care

_____Medication Consultation

_____Other _____

It will be limited to the following types of information:

_____Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
_____Admission and discharge summaries.
_____Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations or testing records.
_____Social, family, educational, and vocational histories
_____Billing records and all information required to secure insurance reimbursement.
_____Academic and educational records and all other school or special education documents.
_____HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here. _____Do Not Release These.
_____Complete copy of medical record.

Dates of care included: From_____ to _____
or it will be one year from date of signature.

Andrea Peterson, LMFT #85722
2378 Maritime Dr. Suite 100
Elk Grove, CA 95758
(916)849-1273

Stacey Thao, IMF #69834
2378 Maritime Dr. Suite 100
Elk Grove, CA 95758
(916)807-0571

Authorization to use and disclose protected health information. (p.2)

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon. If not earlier revoked, this consent terminates one year from the date signed. I have read the above and have also been advised of my right to receive a true copy of this authorization in its entirety and have asked any questions about any thing that was not clear to me and I am satisfied with the answers I have received.

Signature of Patient_____Date_____

Signature of Parent,_____Date_____
Guardian, or Conservator
_____ Date_____

Signature of Witness_____Date_____