Dr. Weissman Psychology
PO Box 1968
Agoura Hills, CA 91301
(818) 336-1041 * (805) 601-7098
DrWeissmanPsychology@gmail.com
DrWeissmanPsychology.com

Authorization for Two-Way Release of Information

I _____ (Patient) hereby authorize **Dr. Weissman** to disclose information about _____ (Patient Name) _____ (DOB) to and receive information from _____ (Designated Person).

Phone: _____ Email: _____

The nature of the disclosure may include:

Medical/Hospital Records	_____	Medical Test Results	_____
Evaluations	__X__	Course of Treatment	__X__
Diagnosis	__X__	Psychotherapy Notes	__X__
Treatment Plans	__X__	Other	_____
Neuro/psychological Tests	__X__		

The purpose of such disclosure:

Coordination of Care	_____	Consultation	_____
Ongoing Treatment	_____	Legal	_____
Evaluation	_____	Other	_____
Medical Care	_____		

The designated information about me may be transmitted by electronic mail or other electronic file transfer mechanisms. **Dr. Weissman**, and the above designated person may discuss by telephone the content of the information released.

This consent is in effect until_____ (or one year if not indicated). I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during psychotherapy or neuropsychological assessment is legally confidential, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children, elderly, or any dependent. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____

Signature of Patient or Personal Representative Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.