**Andrea Guzman, LMFT, LLC**

**Authorization to Release Confidential Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I hereby authorize the two-way disclosure and/or two-way exchange of client’s health information as follows between

**Andrea Guzman, LMFT, LLC** AND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/Agency name Person/Agency Name

**4452 Park Blvd. Suite 204, San Diego**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address Address

**6310-612-2611**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Phone

**PURPOSE FOR AUTHORIZING THE DISCLOSURE OF MY HEALTH INFORMATION:** (Please have client/legal rep initial next to each “X” item)

\_Evaluation

\_Treatment Planning/Course

XOther: diagnosis code and services dates for the purpose of billing only\_\_\_\_\_

**THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:**

(Please have client/legal rep initial next to each “X” item)

\_ Entire Record \_\_\_\_\_\_

\_Psychological Testing Results \_\_\_\_\_\_

\_Diagnosis \_\_\_\_\_\_

\_Social History \_\_\_\_\_\_

\_Psychiatric Evaluation \_\_\_\_\_\_

\_Academic/School \_\_\_\_\_\_

\_Individual Treatment Plan \_\_\_\_\_\_

\_Discharge Summary/Aftercare Plan \_\_\_\_\_\_

\_Substance Abuse History/Treatment \_\_\_\_\_\_

XOther: diagnosis code and services dates for the purpose of billing only\_\_\_\_\_\_\_\_\_

**EXPIRATION** This authorization expires:\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**

I have read and understand the terms of this authorization to release information. I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***If the client is a minor, parent or legal representative must sign below and indicate relationship to client. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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