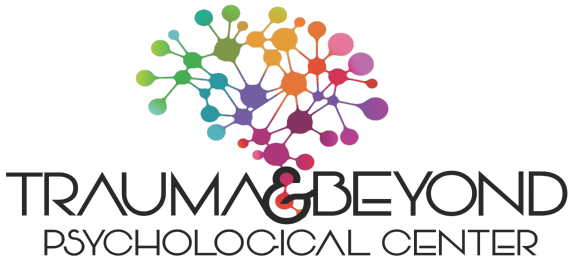


14156 Magnolia Blvd. Suite 101 Sherman Oaks, CA 91423
818-351-3511

Consent to Release/Receive Confidential Information

By signing this document, I, _____ hereby authorize
(Print Name)

_____ to disclose/receive information on _____
(Patient's Name)

Obtained in the course of diagnosis and/or treatment to:

_____
(Name of Person/entity to receive/disclosure information to and from)

_____

(Telephone / Fax)

I also understand that any cancellation or modification of this authorization must be in writing.

This disclosure of information and records authorized herein is required for the following purpose collaboration of treatment.

Education	Legal	Psychiatric	Psychological
Insurance	Medical	Psychometric Testing	Information for Payment Purposes

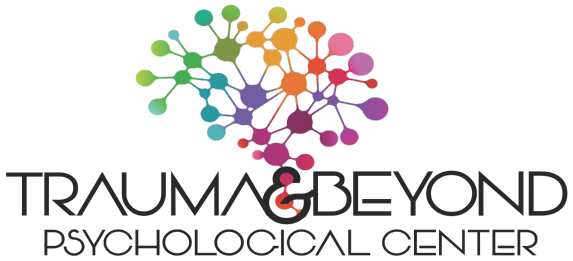
The specific uses and limitations on the types of medical information to be disclosed are as follows:

The authorization should remain valid until: _____

I understand that this information may not be released to any other person or organization with my permission in writing. A photocopy of this authorization shall be considered valid. The information disclosed shall not be used for any purpose other than its intended use. The party requesting this information will destroy or will return the information immediately after the length of time specified, unless the patient has signed a waiver.

Signature of: Patient Parent Guardian

Signature: _____ Date:_____



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Address: _____ DOB: _____ Telephone: _____

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

I understand that I may revoke this authorization at any time upon written notice to Trauma and Beyond Psychological Center. I acknowledge that such revocation will not be effective if Trauma and Beyond ®, has already acted in reliance upon this authorization.

This authorization is valid (if not previously evoked(this consent will terminate upon 365 days from the date of signature of this form, or the following event/condition: n/a, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

Prohibition on Re-disclosure

This information has been disclosed from re cords protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR pat 2. The Federal rules restrict any use of the information to criminally investigate or prose cute any alcohol or drug abuse client.