Carolyn Shoshana Fershtman, JD, Ph.D.
Licensed Clinical Psychologist PSY 22774
621 Cherry Street, Suite 2
Santa Rosa, CA 95404
(707) 528-2441
Fax: (877) 366-4708

AUTHORIZATION TO RELEASE INFORMATION

I,**(name of patient)** _____, (hereinafter "Patient") hereby authorize Dr. Carolyn Shoshana Fershtman , (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

_____
_____
_____

Such disclosure shall be limited to the following specific types of information: _____
_____.

I authorize _____ to disclose to Dr. Carolyn Shoshana Fershtman information related to my treatment. Such disclosure shall be limited to the following specific types of information:

_____
_____
_.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at the above address to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: _____.

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: revoked in writing by patient.

Patient's signature: _____ Date:_____