Andrew M. Leeds, Ph.D.
1049 Fourth Street, Suite G
Santa Rosa, CA 95404
(707) 579-9457

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient's Name: ____

Date of Birth: ___________________________ Social Security Number: ____________________

This is to authorize Dr. Andrew M. Leeds to disclose and release any and all psychological records, treatment notes, results of testing, diagnoses, or any other personal information which would otherwise be considered privileged or confidential, whether written or otherwise to the individual, agency or corporation.

Release information to:

____

(name of individual, agency or corporation)

____

(address)

____

(phone)

I also authorize the above named individual, agency or corporation to disclose and release any and all medical, psychological, legal or educational records, treatment notes, or any other personal information which would otherwise be considered privileged or confidential, whether written or otherwise to Andrew M. Leeds, Ph.D.

This permission is valid until revoked or for a period of one year from the date signed. Permission can he revoked by notifying Dr. Leeds in writing. I understand that after being released, this information may be redisclosed by the person, agency or corporation who has accepted financial responsibility and may no longer be protected. I understand that I may refuse to sign this authorization.

______________________________ ____

(date) (signed)

Client Received ________ Waived ________ a copy of this form.

Revised 12/20/12