SALUS PSYCHOLOGY

Salus (Latin): Health, Safety, Well-Being

Authorization To Release Information

I, _____, (hereinafter "Client") hereby authorize _____, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to (Name, Address/Phone Number):

_____

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: 595 E. Colorado Blvd., Ste. 318, Pasadena, CA 91101 to be effective.

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

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):

_____

_____

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

_____

_____

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client 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: _____

Client's signature: _____ Date:_____