Heather Stone, Ph.D.
Licensed Psychologist, PSY 21112

AUTHORIZATION TO RELEASE INFORMATION

I, _____, (hereinafter "Patient") hereby authorize **Heather Stone, Ph.D.** (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:

_____

_____

_____

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 **3921 Villa Court Fair Oaks CA 95628** to be effective.

This disclosure of information and records authorized by Patient is required for the purposes of coordination of services, treatment planning, and/or patient care.

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.

Patient's signature: _____ Date:_____