Lital Diament, MA, LMFT (LMFT 96310) (818) 519-2815

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO LITAL DIAMENT, MA, LMFT (LMFT 96310)

Date: _____ Participant: _____ DOB: _____

I, _____, hereby authorize the following Facility/Physician/Mental Health Professional to release/exchange records including any information related to medical, surgical, psychological, social, psychiatric and/or substance abuse, diagnosis, treatments, prognosis, counseling, court or legal proceedings, and/or therapy there-in contained.

Name of Facility/Physician/Mental Health Professional:

_____

_____

_____

Please direct the information to: _____ _____
Name **Email Address**

I specifically authorize the following information be released:

_____ Discharge Summary
_____ Psychiatric Evaluation
_____ Psychological Testing
_____ Immunization Record
_____ Physician Progress Notes
_____ Operative Report
_____ History and Physical Examination
_____ Other (please describe):

_____ Court Records
_____ Probation Records
_____ Adoption Records
_____ Lab, Radiological Reports
_____ Physician Orders
_____ Medication Records
_____ Consultation Records

This information is needed for the following purpose(s):

_____ Continued Care _____ Other: _____

This authorization is good for one (1) year from the date signed at which it will be null and void. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon.
I understand revocation must be in writing.

Participant: _____ DOB: _____ Date: _____

_____ _____
Parent/Sponsor (If Participant is under 18) Date