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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize that the party(ies) named below to release and obtain any or all medical, social, psychological, educational, and/or other appropriate information needed for the evaluation and treatment of myself or my minor child(ren), _____DOB = _____ to Dr. Beverly Januszewski. I understand that such information may be integrated into my medical file, and that Dr. Januszewski will preserve the confidentiality of such information according to the policies based on applicable portions of the California Welfare Institutions Code Section 4514.

1. Name: _____
   Address & Phone: _____
   Purpose: _____

2. Name: _____
   Address & Phone: _____
   Purpose: _____

I understand the nature of the records and information that I have requested to be released and the implications of their release. I hereby release Dr. Januszewski and the above parties from any legal liability due to the release of any information. I also understand that I may revoke this authorization at any time by informing the parties above in writing, except to the extent that action based on this authorization has been taken. I understand that the requestor may not further disclose this information unless another authorization is obtained or unless such disclosure is specifically required or permitted by law. I understand that I may request a copy of this authorization and I may inspect or obtain a copy of the information that I am being asked to disclose (as allowed by California Mental Health Law). I understand that treatment will not be conditioned on my providing or refusing to provide this authorization, and that I may refuse to sign. In this case the information will not be able to be obtained or released. A photocopy of this Authorization for Release of Information is as valid as the original. This authorization is valid until revoked by the patient or parent/legal guardian.

_XX_____ _XX_____
Signature of patient or parent/legal guardian Date

_XX_____ _XX_____
Printed name of patient and parent/legal guardian Date

Clinician Approval Section: Required for Patient Access Only
Dr. Beverly Januszewski, the undersigned, hereby approves/disapproves the release of information and records to the party(ies) specified above. If disclosure is disapproved it must be based on the fact that release of the records would cause a substantial risk of significant adverse or detrimental consequences to the patient in seeing a copy of the records requested. (Health and Safety Code 123115). _____ APPROVES RELEASE _____ DISAPPROVES RELEASE (due to the following description of specific adverse or detrimental consequences anticipated):

_____
_____

_____ _____
Signature of Clinician Date & Time