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AUTHORIZATION REQUESTING RELEASE OF INFORMATION

The undersigned authorizes two-way communication between the two parties indicated herein for the limited purpose of assessment, evaluation, and psychotherapy services.
This authorization will become effective immediately and shall remain in effect until revoked in writing by the undersigned or treatment has ceased.

I_____
(Name of Client)

authorize_____
(Name of Party and/or Organization)

_____
(Address)

_____
(City) (State) (Zip) (Phone)

To Provide or Receive From:

LARRY J. HAMILTON, M.A., M.F.T.
23441 SOUTH POINTE DR., SUITE 180
LAGUNA HILLS, CA. 92653

Please provide any and all records pertaining to medical history and/or mental health history and prior treatment. Disclosures shall be limited to the following information:

Treatment Summary
Test Reports
Medical Information
Consultation:
(Specify)_____

Psychosocial History
Lab Reports
School Reports

I release Larry J. Hamilton, M.A., M.F.T. from any legal liability resulting from the release of this information. It is understood that reasonable professional safeguards regarding this information will be taken to protect confidentiality.
I have the right to receive a copy of this authorization upon request and can revoke this in writing at any time.

Signed:_____Date:_____

Witness:_____Date:_____