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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I _____ hereby authorize Lisa A. Maurel, MFT. License No. 32416; to disclose information and records obtained in the course of my diagnosis and/or treatment to:

Name/Entity to whom disclosure is made

Address

Phone

Fax

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This disclosure of information and records authorized herein is required for the following purpose:

assessment and diagnosis medication evaluation medical compliance

recommendations treatment coordination referral

The specific uses and limitations on the types of medical information to be disclosed are as follows:

medications assessment and diagnosis testing results

treatment recommendations and progress coordination of treatment

This authorization shall remain valid until: _____.

Patient Signature: _____ Date: _____.

Parent Signature if patient is a minor: _____.

Reference: California Civil Code Section 56.11.