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AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

I, ________________________*(print your name)* hereby authorize Leslie M. Drozd, Ph.D. to disclose, mutually discuss, release, and/or obtain information and records regarding myself and my child(ren)[1] to __________________*(name of person for Dr. Drozd to speak to)*. This releases Leslie M. Drozd, Ph.D. and ___________________*(name of person for Dr. Drozd to speak to)* to speak to each other. Whereas I understand that I am not and it is not intended that I will be a patient of Dr. Drozd's and whereas I understand that my relationship with Dr. Drozd is solely as a collateral to the treatment of my child, I am signing this release in order that Dr. Drozd, as the therapist for my child, can obtain privileged records from other professionals.

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 Dr. Drozd has taken in reliance upon it. And, I also understand that such revocation must be in writing and received by Dr. Drozd at 1001 Dove St., Ste. 110, Newport Beach, CA 92660 to be effective.

The disclosure of information and records authorized by me is required for the following purpose: screening, assessment, diagnosis, and treatment.

The specific uses and limitations of the types of medical and/or mental health information to be discussed are as follows: Information including but not limited to any and all appropriate information that has been acquired that is pertinent to the treatment that I received as part of family therapy with Dr. Drozd.

Dr. Drozd shall not condition services upon me signing this and I understand that I have the right to refuse to sign this form. She will, though, not contact collaterals without a signed release.

I understand that information used or disclosed about my child 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.

I understand that the information is released may be exchanged by mail, courier, fax, phone, cell phone, e-mail, and/or person.

I hereby release ________________________*(name of person for Dr. Drozd to speak to)* and Leslie M. Drozd, Ph.D. from all legal responsibility or liability that may arise from the act that I have authorized above.

This release is valid until one year from the date this release is signed. A photocopy or fax copy of this signed form is as valid as the original.

__________ ____

today's date parent's signature print name

[1] Child's name_____________and DOB_______ ; Child's name_____________and DOB_______;
Child's name______ and DOB____; Child's name_____________and DOB_______