

Romi Mann, Psy.D.
Clinical Psychologist (PSY 25226)
415.508.7664

Consent to Release Information

Patient's Name: _____ Patient Date of Birth: ___/___/___

Guardian (if minor): _____ Patient Social Security Number: ___-___-___

I request and authorize **Dr. Romi Mann** to release healthcare information of the patient named above to:

Name and/or Organization: _____

Phone #: _____ Email: _____

Fax #: _____

Address: _____

City, State, and Zip Code: _____

This request and authorization applies to:

- My attendance in therapy
- My diagnosis
- My treatment plan
- Information relevant to coordinating care
- Other: _____

I understand that: 1) this authorization is voluntary; 2) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected; 3) I am entitled to a copy of this authorization, should I request one; 4) this authorization will expire 6 months from the original authorization date; 5) I have the right to revoke this authorization at any time, by written notification only, except to the extent that the information has already been disclosed.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

Patient or Guardian's Signature: _____

Today's Date: _____