Leslie Ellen Ray, MS, LMFT
Marriage and Family Therapist, Lic. No. 27444 (California License)
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Authorization for Release of Information

_____ _____
Patient's Name Birthdate

Patient's ID/SSN/Policy #

Street Address City State Zip

I understand that this authorization is voluntary. I understand that my health information may be protected by federal rules and/or state laws.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Leslie Ray in writing, but if I do, it will not have any effect on any actions Leslie Ray took before receiving the revocation.

I hereby authorize Leslie Ray to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from the parties I have indicated below

I hereby authorize Leslie Ray to exchange/release/obtain information:

☐ verbally only ☐ in written form only ☐ both (verbal/written)

Person/organization receiving/communicating the information:

Name: _____

Address: _____

_____

Phone Number: ___(_____)_____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

☐ All
☐ Claims
☐ Eligibility/Benefits
☐ Treatment Plan(s)
☐ Outpatient Progress Reports
☐ Attendance Only
☐ Clinical records used to make benefit determinations (may include HIV/AIDS and/or Substance Abuse information)
☐ All records relating to a Disability claim
☐ All pertinent documentation Leslie Ray deems appropriate for the purpose(s) checked below
☐ Other (describe):

_____

_____

_____

_____

The purpose of this release is (check all that apply):

☐ To allow the clinically appropriate management and coordination of the Member/Patient's mental health, ongoing therapy and/or substance abuse treatment.

☐ Claims Administrative/Payment

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

☐ On _____/_____/_____ (MM/DD/YY), or 60 days after the termination of treatment, whichever is earlier.

OR

☐ Once the following event occurs:

_____

_____

_____

Signature of Patient/Legal Guardian or Patient's Representative — Date

_____

Signature of Minor Patient — Date

_____

Print Name of Patient's Representative — Relationship to Patient

You may refuse to sign this authorization