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Authorization of Use/Disclosure of Health Information

Patient Name _____ DOB _____

I hereby authorize Jennifer Shapiro, Ph.D.. to: *release and receive* information to/from:

Name _____

Address _____

Phone _____ Fax _____

Information to be disclosed may include:

- ◇ Inpatient or outpatient treatment records (physical, psychological, psychiatric)
- ◇ Admission and discharge summaries
- ◇ Psychological or psychological evaluations, reports, assessments, treatment notes, summaries, diagnoses, prognoses, recommendations, testing records, surveys completed by provider or patient.
- ◇ Progress notes
- ◇ Billing records

OR - Only the following records or types of health information (insert dates of treatment, types of treatment or other designation):

This consent authorizes verbal discussion of information and exchange of written information. This consent is valid until treatment termination, unless revoked earlier.

Signature of Patient or Representative

Print Name

Date