Gelareh Solomon, Ph.D.

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Authorization to Obtain, Release, or Exchange Confidential Information

To: _____

Address: _____

Phone: _____ Fax: _____

Re:_____ Date of Birth: _____

I hereby authorize Dr. Gelareh Solomon to ( ) obtain, ( ) release, or ( ) exchange……records and/or oral information concerning:

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment ____ Legal action or consultation

____ Family Counseling ____ Work history, personnel records

Other _____

for the individual for the purpose of_____

This release is restricted to the following kinds of information:

_____

_____

_____

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 release takes effect immediately and shall remain valid until:
_____("Expiration Date")

_____/_____/_____
Client Signature Print Name Date

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative:_____

_____/_____/_____

Therapist Signature Print Name Date