Nancy A. Vierra, MFT
Licensed Psychotherapist
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RELEASE OF INFORMATION

I, (Name of Client)_____hereby authorize Nancy Vierra, MFT to exchange confidential and protected health information regarding my treatment with (designate recipient or organizations to whom information is to be exchanged)_____ .

This authorization allows Nancy Vierra, MFT to exchange the following information: (check those that apply)
( ) Entire File
( ) Diagnosis
( ) Prognosis
( ) Treatment Plan
( ) Symptoms
( ) Summary of Treatment
( ) Dates of Treatment
( ) Progress to Date
( ) Information as deemed appropriate by my therapist.
( ) Other:_____

I authorize the exchange of the information above for the following purpose:
( ) Treatment Planning
( ) Other:_____

The recipient or entities may use the information described above only for the following purpose(s):
( ) Treatment
( ) Other:_____

This authorization shall remain in effect until:
( ) End of Treatment
( ) Other:_____(expiration date)

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke or modify this authorization, in writing, at any time. I understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and that the

HIPAA Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

Client Name:_____
(please print)

Signature:_____Date:_____

If you are a minor:

Name of Parent or Legal Guardian or Custodial Parent:

_____
(please print)

Signature of Parent/Legal Guardian/Custodial Parent:_

Signature:_____Date:_____