Authorization to Release Information

I, ____________________,DOB:_________________________, hereby authorize Brandon Vazirian MFT to exchange clinical information and records obtained in the course of my diagnosis and/or treatment with:

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This exchange of information and records authorized herein is required for the following purpose(s):

___ Coordination of care/treatment

___ Coordination/allocation of benefits

___ Other: ____

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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 consent is subject to revocation by the undersigned at any time except to the extent that action has already been taken in reliance herein. If not earlier revoked, this authorization shall terminate one year from the date it was signed.

I have carefully read and I understand the foregoing information. I consent to the release of the above-specified clinical information for the purposes listed above. I further release Brandon Vazirian, MFT from any liability incurred from the release or exchange of this information to the above designated persons or agencies.

Signature of Patient______________________________________ Date_______________

Signature of authorized and/or responsible individual/guardian:

____ Date_______________