

Kristina Monroe, Psy.D.

Licensed Psychologist

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AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** _____, (hereinafter “Patient”) hereby authorize Kristina Monroe, Psy.D., CA: PSY24929, NY: 019303, NJ: 35SI00615900), (hereinafter “Provider”) to disclose mental health treatment information and records obtained in the course of psychotherapy and/or psychological assessment of Patient, including, but not limited to, therapist’s diagnosis of Patient, to:

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider at 8235 Santa Monica Blvd., Suite 303, West Hollywood, CA 90046 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

Such disclosure shall be limited to the following specific types of information:

Therapist shall not condition treatment upon Patient signing this authorization, and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Patient’s signature: _____ Date: _____