VINDER LALLIAN, MA, LMFT

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AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

1. _____hereby authorize _____
   Patient or Patient's Representative Name of Provider

To release and/or obtain confidential information obtained during the course of treatment. This authorization is given for following persons involved in my treatment:

_____

_____

_____

This Authorization permits obtaining or releasing of the following information:

_____Any and All Information Necessary

_____Diagnosis _____Treatment Plan _____Summary of Treatment _____Progress to Date

_____Clinical Test Results _____Dates of Treatment _____Patient Records _____Prognosis

_____Others_____

_____

I authorize the obtain/release of the information described for the following purpose (s):

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of the authorization must be in writing.

This Authorization shall remain valid until: _____
Expiration Date

By: _____ Date: _____
Patient or Patient's Representative

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

Representative: _____