Laura E. Forsyth, Ph.D. Licensed Psychologist, PSY 17938

Authorization to Release or Exchange Information

I, _____, the undersigned, DOB _____, authorize Laura E. Forsyth, Ph.D., to disclose, release or exchange information about my mental health treatment with:

_____ _____
Name Relationship to Me

_____ _____
Address Phone

_____ _____
City, State Fax

Purpose: _____

The following information may be ❑ released or ❑ exchanged (two-way, ongoing):

❑ attendance in therapy	❑ diagnosis
❒ progress in treatment	❑ information relevant to coordinating care
❑ treatment plan	❑ copy of my clinical records
❑ assessment findings	❑ drug/alcohol treatment
❑ other:	
❑ this information is to be limited as follows:	

I understand that:

- this authorization is valid until _____, or 24 months from the date below
- I have the right to receive a copy of this authorization
- I may cancel or modify this at any time by submitting a request in writing to Dr. Forsyth at 1601 Carmen Dr., Ste. 211, Camarillo CA 93010
- revoking my authorization will not apply to any actions taken in reliance on it
- my therapy with Dr. Forsyth is not conditioned on my consent to this authorization
- a copy of this authorization with my signature is as valid as the original

In consideration of this authorization, I release the above parties from any legal liability resulting from the release of this information.

_____ _____
Signature Date

1601 Carmen Drive, Suite 211, Camarillo, CA 93010 ✆ 805.795.2131
www.drlauraforsyth.com