

Authorization to Exchange or Release Information

By signing this document, I, _____, hereby authorize **Raymond F. Cameron, M.A., MFT**
(Client) (Treatment Provider)

Disclose mental health information and records obtained in the course of my diagnosis and/ or treatment.

Obtain mental health information and records to support the course of my diagnosis and/ or treatment.

Name: _____ Title: _____

Address: _____

Telephone #: _____ Fax#: _____ Email: _____

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 Treatment Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and be received by Treatment Provider to be effective at: **32605 Temecula Parkway, Suite 207, Temecula, CA 92592**

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

Coordination of Treatment and Interventions

The specific uses and limitations on the types of medical information to be disclosed and/ or obtained are as follows: (Please check all that apply)

Academic & Behavioral Observations	Diagnosis
Psychological Test Results	Treatment Record
Psychiatric Evaluations & Medications	Social History
Medical Information	Discharge Summaries
Social Services / CWS Records	Entire Record
Other:	

Client 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 Federal Privacy Rule, although applicable California law may protect such information. This consent becomes effective on _____
Unless revoked by Client in writing, this authorization shall remain in effect until _____.
A copy or facsimile of this consent is to be considered the same as the original.

Client

Date

Parent or Legal Guardian

Date

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Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com

Client: _____