THE BERKELEY THERAPY INSTITUTE
1749 MARTIN LUTHER KING, JR. WAY
BERKELEY, CALIFORNIA 94709

TELEPHONE (510) 841-8484
FACSIMILE (510) 540-1707

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____

Date of Birth:_____

I, _____,hereby authorize Brian S. Sedgeley, MA,
Patient OR Personal Representative hereinafter "Provider"
to obtain, disclose and verbally exchange mental health treatment information and records obtained in the course of my treatment with the following person or agency:

Name:_____

Address:_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time unless the Provider has already acted in reliance of it. I understand that any modification or revocation of this authorization must be in writing, signed by me or on my behalf, and delivered to the Provider at Provider's address to be effective.

This disclosure of information and records is required for the following purpose(s):

I authorize disclosure of <u>all</u> my records OR such disclosure shall be <u>limited to</u> the following specific types of information:

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form.

This authorization shall remain valid for one year or until (enter date of event):_____

I understand 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.

Patient signature:_____Date:_____

OR Personal Representative Signature:_____

Relationship to Patient:_____