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AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby authorize this release of information: [Name]

FROM: Sudi Khosropur, M.A., AMFT
TO: [Name & Title]]_____
[Address]_____
[Telephone & Email]_____
[Relationship]_____

This authorization will be valid for one year from the date below. I understand that I may cancel this authorization at any time by written request. _____ and that I have a right to receive a copy of this release if I so request. _____

The information released may include psychotherapy notes taken by Sudi Khosropur MA, AMFT in the course of, or relating to, diagnosis or treatment, including HIPPA protected health information. The purpose of this release is:

_____
_____
_____

I understand that this information, or any other information, may not be released to any other person or organization, without my further permission.

Client_____ _____
[Signature] [Name]

Parent/Guardian_____ _____
[Signature] [Name]
Date_____

Witness_____ _____
[Signature] [Name]
Date_____