Hoai-Thu Truong, Ph.D., Clinical Psychologist (PSY 19960)

415 Cambridge Avenue, Suite 3, Palo Alto, CA 94306
(650) 327-3003   www.paloaltocounseling.com

AUTHORIZATION TO RELEASE INFORMATION:

I,______________________________, (hereinafter "Patient") authorize Hoai-Thu Truong, Ph.D. (hereinafter "Provider"):

_____ (please initial) **to RELEASE verbally or in writing any material** from any professional services she has rendered to me (including, but not limited to, mental health treatment, psychotherapy, consultation, psychodiagnostic testing) to the person(s) or staff of the clinic, office, agency or institution named below.

_____ (please initial) **to RECEIVE any information** from the person(s) or staff of the clinic, office, agency or institution named below.

_____ (please initial) **to RELEASE verbally or in writing ONLY the following material** from any professional services she has rendered to me:

____

This applies to services rendered (specify dates, if applicable): ______________________

_____ (please initial) **to RECEIVE verbally or in writing ONLY the following material** from professional services rendered to me:

____

This applies to services rendered (specify dates, if applicable): ______________________

Name & Institution: ____

Address, City, Zip: ____

Phone: Area Code (________) ____

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 Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 415 Cambridge Ave. Ste. 3, Palo Alto, CA 94306 to be effective.

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

Patient understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable California law may protect such information.

This authorization shall remain valid until: ______________________________________

Patient Signature: ______________________________________ **Date**: _______________