Suzannah Ferron
Licensed Marriage and Family Therapist, MFC 84622
3171 Los Feliz Boulevard, Suite 200, Los Angeles, California 90039
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Authorization For Exchange/Release/Disclosure Of Protected Health Information

Name of client: _____ Date of birth: _____
Street Address: _____

AUTHORIZES EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION BETWEEN:

Suzannah G. Ferron, MA, LMFT
MFC 84622
21243 Ventura Blvd #228
Woodland Hills CA 91364
3171 Los Feliz Boulevard, Suite 200
Los Angeles, California 90039
818-381-9819

AND: _____
Name of Health Care Provider/Other
_____
Street Address
_____
City, State, Zip
_____
Phone/Fax

INFORMATION TO BE EXCHANGED/RELEASED/DISCLOSED:
[ ] Diagnosis [ ] Patient Records [ ] Dates of Treatment [ ] Clinical Test Results [ ] Prognosis [ ] Progress to Date [ ] Treatment Plan [ ] Summary of Treatment [ ] Any and All Necessary Information [ ] Other: _____
PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE: (check applicable categories)
[ ] Client's request: _____
[ ] Other (specify): _____

I understand that by signing and authorizing the PHI exchange/release may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____.

Signature of client/legal representative: _____Date: _____
Relationship to client: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to receive a copy of this Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Revoke this Authorization: I understand that I have the right to revoke this Authorization at any time by notifying my therapist in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to my therapist (see address at top of page). I also understand that a revocation will not affect the ability of my therapist or any other health care provider to use or disclose the health information for reasons related to the prior reliance of this Authorization. Conditions: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Revocation of Authorization
Signature of client/legal representative: _____Date: _____
Relationship to client: _____