**Dr. Robyn El-Bardai, PsyD** **Clinical Psychologist** **CA License PSY26738**
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# RELEASE OF INFORMATION FORM

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorizes the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Name _____Date of Birth _____

I authorize Dr. Robyn El-Bardai, PsyD, CA Lic. # PSY26738 to disclose mental health information to:

Name: _____

Address:_____

Telephone: _____ Fax: _____ Method:[ ] Mail [ ] Verbal [ ] E-Mail [ ] Fax

The dates of service and the type(s) of information to be used or disclosed are as follows:

Dates of treatment: _____

[ ] Medical / Clinical / Psychological / Psychiatric Information

[ ] Treatment plans, background information

[ ] Psychological /neuropsychological / psychosocial assessment.

[ ] Other _____

The purpose of this disclosure or use is for the following reason:

[ ] Medical/Psychological treatment or follow-up

[ ] Legal

[ ] Disability

[ ] Request of patient

[ ] Other _____

I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time. Understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that my treatment or continued treatment by the provider checked above is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

**Pt Signature (or authorized representative*)** _____ **Date** _____

*Note: If you are signing as the legally authorized representative of the patient, please indicate your relationship to the patient here: [ ] Parent [ ] Guardian [ ] Other