Margaret Grundstein | M.F.T.

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Client's name_____D.O.B.____/____/____

I_____or _____

Name of Patient Parent/Guardian

Hereby authorize_____

Name of person/agency

_____

Address (Street,City,State,Zip)

To release/and/or exchange professional and/or medical information regarding my child and/or myself to:

Margaret Grundstein, MFT
11340 W.Olympic Blvd, Ste. 381
Los Angeles, Ca. 90064

Information to be disclosed pertaining to the assessment and/or treatment of the following conditions (check pertinent boxes)

_____Medical_____Drug_____Alcohol_____Psychiatric_____School

and should be limited to the following types of information:

_____Diagnosis_____Discharge Summary_____Psychiatric Evaluation_____Progress Notes

_____Psychological Test Results_____Educational_____Assessment_____Behavioral Reports

_____Other

The disclosure is required for:

_____Evaluation_____Treatment_____Other

This authorization is effective from____/____/____and maybe revoked at any time by the undersigned. This authorization is good until____/____/____.
I understand I have the right to receive a copy of this authorization.

_____

Signature of client Date

_____

Signature of Parent/Guardian Date

_____

Address (Street, City, State, Zip)

_____

Parent/Guardian Telephone (home) (work)

_____

Signature of Witness Date

Adult, Child
and Family Therapy
11340 W. Olympic Blvd.
Suite 381
Los Angeles, California
90064

MFT LICENSE #50240

310 313 2979