Marlene M. Maheu, Ph.D.
Licensed Psychologist #PSY 11921
106 Thorn Street, San Diego, CA 92103
(858) 277-2772

Authorization to Release Information

Please sign the statement below giving your permission for me to communicate with the following

individual, agency, or insurance companies on your behalf:______________________________
(name of individual or group to be contacted)

located at: ____, phone:______________
(address, city, state, zip)

I, ______________________________, born on____________, hereby authorize Marlene M. Maheu, Ph.D.
(*printed client name- and maiden name , if applicable)*

to disclose/obtain the following information about me/my child ____________________from clinical records:
(name of child)

- ❑ Intake Summary
- ❑ Psychological Assessment
- ❑ Diagnosis
- ❑ Treatment Plan
- ❑ Medication Management
- ❑ Social/Family History
- ❑ Medical History
- ❑ Toxicological Reports/Drug Screens
- ❑ Closing or Treatment Summary
- ❑ Other: ______________________

The purpose for the release of this data shall be:

❑ Treatment planning Other: ______________________________

I understand that I have the right to revoke this authorization at any time unless Dr. Maheu has already taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Dr. Maheu at: 106 Thorn Street, San Diego, CA 92103, to be effective.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. This authorization and request to release or obtain information from my records and its implications are fully understood, and is made voluntarily on my part. This consent will expire after one (1) year from the date on which it was signed. A photocopy or a facsimile of this authorization shall be valid as the signed original on file. I understand I have the right to receive a copy of this authorization upon my request, and that treatment is not conditional upon signing this authorization, unless such disclosure is permitted by law.

______________________________ ______________________________ ____________
Signature of patient, parent or guardian *Printed Name* *Date*

Relationship to patient:
- ❑ Self
- ❑ Parent of a minor (less than 14 years of age)
- ❑ Guardian or person legally authorized to act in the behalf of the patient

I have discussed the above issues with this person and have, in my professional judgment based on my observations of behavior and responses, reason to believe that this person is competent to give informed and voluntary consent.

____ ____________________
Marlene M. Maheu, Ph.D. *Date*

❑ Copy accepted by Client ❑ Additional copy kept by Professional