Mallory D. Hepp, LCSW
5535 Balboa Blvd. Suite 206 Encino, CA 91316
Phone: 818-938-1937

Consent to Release Information

I, _____ hereby authorize Mallory D. Hepp
Client Name – Printed

and the party delineated below to disclose and/or obtain information and/or records regarding my diagnosis and treatment and other pertinent information. I realize that the exchange of information between all parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care.

Authorize: Mallory D. Hepp
5535 Balboa Blvd. Suite 206 Encino, CA 91316
Phone: 818-938-1937

Communication with:
Name: _____
Address: _____
Phone: _____
Fax: _____

Communication of the following information: (circle items)
Psychosocial
History & Physical
Treatment Plan
Discharge Summary
Verbal Communication
Other: _____

INFORMATION TO BE RELEASED IN THE FORM OF:

☐ **FAX** ☐ **PHOTOCOPY** ☐ **TELEPHONE**

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: ***Consent Expires on (Date: _____). If no date is specified then the release is valid for <u>one year</u> from the date below. If a client wishes to revoke their consent they should speak to their Therapist and complete the Revocation of Consent to Release Information Form.***

_____ _____
Client or Guardian Signature Date

_____ _____
Witness Date