Ben Novell, MS, LMFT, LPCC
Marriage and Family Therapist
State License MFC25733

Janelle K. Novell, MA, LMFT, RPT-S
Marriage and Family Therapist
State License MFC32101

Authorization for Release/Exchange of Information

By signing this document I, _____ hereby authorize _____
Patient Treating Therapist

to disclose mental health treatment information and records obtained in the course of Provider's treatment of Patient, including, but not limited to, Provider's diagnosis of Patient, to be released to:

Name: _____ Title: _____

Address: _____

Telephone #: _____ Fax #: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that a copy or facsimile of this consent is to be considered the same as the original. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that to be effective such revocation must be in writing and received by Provider at:

29748 Rancho California Road
Temecula, CA. 92591

This disclosure of information and records authorized by Patient is required for the following purpose:

_____
_____
_____

Such disclosure shall be limited to the following specific types of information: ***(Please check all that apply)***

- ☐ Academic Behavioral Observation
- ☐ Psychological Test Results
- ☐ Psychiatric Evaluation / Prescriptions
- ☐ Medical Information
- ☐ Social Services record
- ☐ Other Information: _____
- ☐ Diagnosis
- ☐ Treatment Record
- ☐ Social History
- ☐ Discharge Summary
- ☐ Entire Record

Patient understands 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 Federal Privacy Rule, although applicable California law may protect such information.

This consent becomes effective on _____. Unless revoked by Patient in writing, this authorization shall remain in effect until: _____, ☐ two years, ☐ termination of treatment, ☐ one year after treatment termination.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian Date