R O B E R T N O R G A A R D, L M F T
Licensed Marriage and Family Therapist
mfc 42553

www.robertmft.com
415.419.2404

Authorization to Disclose Protected Health Information/GENERAL RELEASE OF CLINICAL INFORMATION TO A THIRD PARTY. This form allows Robert Norgaard, LMFT to share confidential information about your case with your the person of you choice as indicated below. This is a 2 way release. No information will be released without your signed authorization. Once signed, all information about our work together may be released in the form of a summary. This includes notes, diagnosis, summaries of your case that include my impressions of which some of this information may be new to you, and/or other information about your case that may be relevant to this request. Robert Norgaard reserves the right to amend or limit any information about your case if deemed potentially harmful to our ongoing work or may affect your mental state-this is a determination based on my clinical judgement/impressions of your case.

PATIENT INFORMATION

Name of patient:

Address of patient:

MENTAL HEALTH PROVIDER INFORMATION

Name and License of Treating Mental Health provider:

Robert Norgaard, LMFT, MFC 42553

Phone number of Mental Health provider: 415-419-2404

Dates that this Release of information is valid:

Start Date:

End date:

Individual or Organization being contacted by Robert Norgaard, LMFT

Name of Individual or organization being contacted:

Address of Individual or name of organization being contacted:

Phone number of INDIVIDUAL or Organization:

FAX number of INDIVIDUAL or Organization:

EMAIL OF PERSON/ORGANIZATION being contacted:

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RELEASE OF CONFIDENTIAL INFORMATION

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date or the dates as stated by the patient in this document. Once signed, this will constitute a release of your clinical information. By signing this voluntary release, you fully understand that you are waiving your right to keep your personal, confidential information about your treatment with Robert Norgaard. Robert Norgaard is released of all liability regarding your records and the interpretation of those records by THE INDIVIDUAL or Organization or the public should they be made aware of your record/clinical information.

Important Rights and Other Required Statements You Should Know

1. You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

2. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.

3. You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Signature of the Client (Patient)

MUST BE LEGIBLE

I completely understand that I am giving Robert Norgaard permission to release all information about my psychotherapy case with the above.

Signature_____ Date (required) _____

Printed Name_____ Date_____