JANEEN LOCKER, PH.D., A PSYCHOLOGY CORPORATION
CLINICAL PSYCHOLOGIST PSY 17889
3101 OCEAN PARK BLVD., STE. 304
SANTA MONICA, CA 90405
(310) 850-3933

AUTHORIZATION TO RELEASE INFORMATION

I, (name of patient) _____, (hereinafter "Patient") hereby authorize (name of psychologist)__ Janeen Locker, Ph.D.___ , (hereinafter "Provider") to release any and all information and related records regarding my psychological treatment from Janeen Locker, Ph.D. to the facility or person(s) named below.

I also authorize release of any and all information and related records regarding my psychological treatment to Janeen Locker, Ph.D. from the facility or person(s) named below.

This information may be needed for clinical consultation, evaluation, or treatment planning. This consent shall become effective _____ and is subject to revocation at any time except to the extent that disclosure has already taken place in reliance on it. 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. And, I also understand that such revocation must be in writing and received by Provider at 3101 Ocean Park Blvd., Suite 304, Santa Monica, CA 90405 to be effective. If not previously revoked, this consent will terminate when treatment terminates.

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. 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 HIPAA Privacy Rule, although applicable California law may protect such information.

_____
(Name of Person or Facility)

_____
(Phone Number or Fax)

Patient's signature: _____ Date:_____

Guardian's signature (if minor) : _____ Date:_____