AUTHORIZATION OF RELEASE
OF
PROTECTED HEALTH INFORMATION

By signing this document, I, _____ (hereafter "Patient") or my parent or legal guardians of a minor, hereby authorize James A. Staunton, MFT (hereafter "Provider") 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:
(name and functions of the person or entity to whom disclosure is to be made)

_____

_____

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 I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at: 3636 4th Avenue, Suite 205, San Diego, California 92103 to be effective.

This disclosure of information and records authorized by Patient (or Parents or legal guardians) is required for the following purpose:

_____

_____

The specific uses of and limitations on the types of medical information to be discussed are as follows:

_____

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Provider shall not condition treatment upon Patient signing this authorization.

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

This authorization shall remain valid until: _____.

_____ _____

Patient or Parent or Legal Guardian Date