



Dr. Bergin Family Counseling Services

AUTHORIZATION TO RELEASE INFORMATION

I, (PRINT YOUR NAME) _____, hereby authorize Dr. Bergin, LMFT, of 6960 Magnolia Ave., Suite 103, Riverside, CA 92506 to release information to, or obtain information from: (PRINT NAME AND ADDRESS OF OTHER[S]) _____

regarding: myself as patient, or (PRINT PATIENT'S NAME) _____, as patient for whom I am parent, legal guardian, or authorized representative. Patient's date of birth is ____/____/____

Information authorized for release is:

Any and all psychological/medical information, billing records, medical records, facts, reports, notes, history, professional opinions, nurse's and secretarial notes, hospital records, raw test data and test results, and any other documents and/or things, concerning or obtained through interview, examination, psychotherapeutic treatment or counseling, testing, or records of others regarding but not limited to, evaluation, assessment, history, diagnosis, prognosis, and treatment interventions and progress relating to my (or the patient's) medical, psychological, counseling, alcohol use, drug use, vocational, and educational background, conditions, and behavior.

Or, other as specified: _____

I understand that Dr. Bergin will use any and all such information received only in my (or patient's) evaluation, assessment, diagnosis, prognosis and treatment, and in reports, deposition, or testimony. I also understand that Dr. Bergin has no control over how "Other(s)" use information released to them.

I understand that release, as it is used here, means to provide, disclose, report, discuss, testify, or give copies of documents. I understand that obtain, as it is used here, means to question, discuss, or get copies of documents.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. Unless expressly revoked, this authorization becomes effective immediately and shall remain in effect for one year after the signature date below. Revocation shall be in writing with proof of receipt by Dr. Bergin.

I have read the above and fully understand its content in its entirety. I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received:

YES NO INITIAL _____

SIGNATURE: _____

DATE: ____/____/____

WITNESS: _____

DATE: ____/____/____