Gwen Grabb, M.F.T.
334 Tejon Place
Palos Verdes Estates, CA 90274
(310) 373-9090

Release of Information

Please sign the statement below giving your permission for me to communicate with the following individual, agency, or insurance company on your behalf:

_____
(Name of individual, agency, company to be contacted)

_____
(Address, city, state, zip of said individual, agency, company)

_____
(Phone/fax)

I, _____ , born on _____, hereby authorize
(Name of patient/guardian) (Birthdate)

Gwen Grabb, M.F.T to disclose/obtain (circle one or both) the following information from clinical records:

- ❑ Diagnosis and dates of treatment
- ❑ Summary of treatment
- ❑ Psychological evaluation/assessment
- ❑ Relevant treatment records
- ❑ Other: Phone conversations

regarding myself/my child, _____
(Child's full name)

for the following purpose: Coordination of Care.

This authorization and request to disclose or obtain information from my records will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

Patient Name/Guardian Name _____

Patient/Guardian Signature _____ Date _____

Relationship to patient:

- ❑ Self
- ❑ Parent of a minor