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RELEASE OF INFORMATION

I, (Name of Client) _____ hereby authorize (Name of Provider) _____ to exchange confidential and protected health information regarding my treatment with (Name of Recipient or Entities to Whom Information is to be Exchanged) _____.

This authorization allows Stephanie T. Ho, Ph.D. to exchange the following information:

( ) Entire file
( ) Diagnosis
( ) Prognosis
( ) Treatment plan
( ) Symptoms
( ) Summary of treatment
( ) Dates of treatment
( ) Progress to date
( ) Other: _____

I authorize the exchange of the information above for the following purpose:

( ) Treatment planning
( ) Other: _____

The recipient or entities may use the information described above only for the following purpose(s):

( ) Treatment
( ) Other: _____

This authorization shall remain in effect until:

( ) End of treatment
( ) Other: _____ (expiration date)

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke or modify this authorization, in writing, at any time by submitting written notification of that revocation or modification.

I understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and that the HIPAA Privacy Rule may no longer protect such

information, although the re-disclosure of such information may be protected by applicable California law.

Signature of client: _____ Date: _____

Signature of parent/guardian, if minor: _____ Date: _____