Pamela Singer, Psy.D.
Licensed Clinical Psychologist

2225 E. Bayshore Rd. Ste. 200 Palo Alto, CA 94303 California License PSY24690
1640 Valencia Street San Francisco, CA 94110 pamelasingerpsyd@gmail.com

Authorization for Release of Information

I, ______________________________, hereby authorize the release of clinical records and information pertaining to my mental health history, treatment, and services rendered between Dr. Pamela Singer the following individuals/organizations:

Name Phone Email___________

____

____

____

____

____

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Dr. Singer unless I request otherwise. I may withdraw this consent at any time. If withdrawn, I understand that Dr. Singer may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I also agree to pay any fees, if applicable, associated with copying, reviewing, and mailing of records.

Signature of client: ____ Date: _______________

Signature of Guardian:_____________________________________ Date: _______________

___________Initial here if you wish to also authorize the release of information between all individuals listed above.