Requesting Clinician: Angela Bisignano, PhD PSY # 26894
2516 Via Tejon Ste., 303 Palos Verdes Estates, CA 90274 P / (424) 206-9055

Authorization to Release Information/Records

I, (name of patient) _____ DOB: _____
hereby authorize a mutual disclosure of information between Angela Bisignano, PhD, and the following individual or institution:
Name: _____

Address: _____

Phone: _____FAX_____

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

- ☐ My attendance in Therapy
- ☐ Clinical Evaluation
- ☐ Diagnosis
- ☐ Treatment
- ☐ Test Results
- ☐ Information Relevant to Coordinating Care
- ☐ Treatment Summary and/or Termination
- ☐ Other (please explain in detail)

_____
_____

Disclosure Authorization: This authorization shall become effective immediately and shall remain in effect for 120 days unless revoked by me in writing. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I understand that the requestor may not further disclose this information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I understand that I may request a copy of this authorization and I may inspect or obtain a copy of the health information that I am being asked to use or disclose (as allowed by California Mental Health Laws). I understand that treatment will not be conditioned on my providing or refusing to provide this authorization and that I may refuse to sign. In this case the information will not be able to be obtained.

Date: _____ Time: _____ am/pm

Signature: _____

If signed by someone other than the patient state legal relationship to the patient: _____

Clinical Approval Section: Required for Patient Access Only
The undersigned (licensed psychologist) that is in charge of the patient hereby approves /disapproves the release of information and records to the party specified above. If disclosure is disapproved it must be based on the fact that release of the records would cause a substantial risk of significant adverse or detrimental consequences to the patient in seeing a copy of the mental health records requested. (Health & Safety Code 123115)

☐ Approves Release ☐ Disapproves Release/Include description of specific adverse/detrimental consequences anticipated.

Signature of Clinician: _____Date: _____