Peninsula Behavioral Health
providing evidence-based psychotherapy to the bay area

Dana Steidtmann, Ph.D.
Clinical Psychologist
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AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I, ____
(Your name)

residing at: ____
(Your address)

hereby give my consent to Dana Steidtmann, Ph.D. to release personal health information contained in my Clinical Record regarding:

____

to: ____
(Recipient of confidential information)

____
(Address)

____
(Telephone number of recipient)

For the purpose of: ____

____

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Dr. Steidtmann unless I request otherwise. I may withdraw this consent at any time. If withdrawn I understand that Dr. Steidtmann may not further use or disclose the medical information

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unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I understand that the information being disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and may no longer be protected by this privacy rule.

I also agree to pay any fees, if applicable, associated with copying, reviewing and mailing of records.

Signature: ___________________________________ Date: ________________

Printed Name: _______________________________

ADDITIONAL RELEASE OF INFORMATION
Complete to allow your other provider(s) to consult with me, if applicable

In addition, I authorize ____ to release clinical records and information pertaining to my mental health history, treatment and services rendered to Dr. Dana Steidtmann.

Signature: ___________________________________ Date: ________________

Printed Name: ______________________________