



Peninsula Behavioral Health

providing evidence-based psychotherapy to the bay area

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: _____
Last First M.I.

DOB: _____ Phone Number: _____

I hereby authorize Dr. Sarah Adler, 518 Hamilton Avenue, Palo Alto, California 94301, to:

Communicate with Release Treatment Summary to Release Clinical Record to

Name of Person or Organization Receiving Information

Mailing Address

City

State

Zip Code

Phone Number

Purpose: The specified recipient may use the health information authorized on this form solely for the following purpose(s):

Expiration: This authorization becomes effective immediately and shall expire on:

Date

SARAH ADLER, PSY.D.
CA PSY 25315
518 Hamilton Avenue
Palo Alto, California 94301
(650) 468-0771
sarah@penbh.com

My Rights:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me, or unless the use or disclosure is specifically permitted by law.
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that Dr. Adler has already disclosed the information.
- I have a right to receive a copy of this authorization.

Printed Name of Patient

Date

Signature of Patient