Peninsula Behavioral Health

providing evidence-based psychotherapy to the bay area

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I, ____

(Your name)

residing at: ____

(Your address)

hereby give my consent to __Jay Schulz-Heik, Ph.D.; PSY24672_____________

__518 Hamilton Ave.__________________________

__Palo Alto, CA 94301________________________

__tel: 650 427-0819__________________________

__email: jay@penbh.com_______________________

to release personal health information contained in my Clinical Record regarding:

__individual psychotherapy____

to: ____

(Recipient of confidential information)

____

(Address)

____

(Telephone number of recipient)

For the purpose of: _Treatment planning and consultation______________________

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Dr. Schulz-Heik unless I request otherwise. I may withdraw

this consent at any time. If withdrawn I understand that Dr. Schulz-Heik 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 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.

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 _Jay Schulz-Heik, Ph.D.________________________________.

Signature: __________________________________ Date: _______________

Printed Name: _______________________________