Candy Katoa, Psy.D.

Clinical Psychologist

CA PSY 24477

AUTHORIZATION TO RELEASE INFORMATION

I, ____, hereby authorize Candy Katoa, Psy.D., to

disclose my child ____________________________________'s mental health treatment information and records obtained in the course of psychotherapy treatment to: *(list name and contact info)*

____

____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless my provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by my child's provider at 1131 Irving Street, San Francisco, CA 94122 to be effective.

My authorized disclosure of information and records is required for the following purpose:

____

The specific uses and limitations of the types of medical information to be discussed are as follows:

____

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

____

My provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: ____

Parent/Guardian signature: ______________________________ Date:__________________