AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Copies of this signed authorization will be considered as valid as the original

This authorization grants permission to **Patricia D. Brunner, Ph.D.** to discuss orally or in writing or by Photostat or facsimile the authorized information regarding your condition (or your children's) while under her observation, treatment or evaluation.

I hereby authorize Patricia D. Brunner, Ph.D. to release to _____*(initial)* **and obtain information from _____***(initial)***:**

_____

_____

_____

Records and information regarding:

_____ _____
(Patient's name) (Date of Birth)

For the purpose of:

_____

Information to be released: (*choose one*)

Either the entire file can be released _____(*initial*) **or**
The following specific information may be released: _____
_____ _____(*initial*)

Duration: (*choose one***)**

This authorization shall become effective immediately and shall remain in effect for **one year** from the date of signature _____(*initial*) **or**
Until the following specific date: _____ _____(*initial*)

Revocation:

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to Patricia D. Brunner, Ph.D. at 7777 Greenback Lane, Suite 100A, Citrus Heights, CA 95610. My revocation will be effective upon receipt, but will not be effective to the extent that it has already been acted upon in reliance of this Authorization.

Redisclosure:

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected.

I further release Dr. Brunner from any liability arising from the release of information to the person, agency, or institution designated above.

_____ _____
Signature of patient or other (specify relationship) Date