Margaret Grundstein | M.F.T.

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

By singing this document, I_____
Name of Patient Parent/Guardian
Hereby authorize _____
Name of person/agency

To release/and/or exchange professional and/or medical information regarding my child and/or myself to:

Margaret Grundstein, MFT
2001 S Barrington Ste. 203
Los Angeles, Ca. 90025

Information to be disclosed pertaining to the assessment and/or treatment of the following conditions (check pertinent boxes)

_____Medical _____Drug _____Alcohol _____Psychiatric _____School

and should be limited to the following types of information:

_____Diagnosis _____Discharge Summary _____ Psychiatric Evaluation
_____Progress Notes _____ Psychological Test Results _____ Educational
_____ Assessment _____Behavioral Reports _____Other

The disclosure is required for _____Evaluation _____Treatment _____Other

This authorization is effective from____/____/____and maybe revoked at any time by the undersigned. This authorization is good until____/____/____. I understand I have the right to receive a copy of this authorization.

_____
Signature of client or legal representative Date

Adult, Child
and Family Therapy
2001 S. Barrington
Suite 203
Los Angeles, Ca. 90025

MFT LICENSE #50240

310 313 2979