Marsha Hewlett, Ph.D.

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Authorization To Use and Disclose Protected Health Information:

Name _____Birth date_____
Home Address: _____

_____, California _____ (____) _____
City Zip Area

I request all information and/or records from following individuals to be sent to Dr. Hewlett

Phone_____
FAX _____

1. _____
Name Mailing Address City, Zip

Phone_____
Fax _____

2. _____
Name Mailing Address City, Zip

Phone_____
Fax _____

3. _____
Name Mailing Address City, Zip

I, _____, the individual listed above, hereby authorize the above listed agencies, individuals to disclose to Dr. Hewlett and her respective agents, employees all available information regarding my child. This release includes telephone or face-to-face exchange to and from the psychologist in regard to needed clinical information. This consent is subject to revocation by the parent at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked, it shall terminate one year subsequent to the signature date. Release or transfer of the disclosed information is prohibited by law except ;as required by the Court. I understand I have the right to retain a copy of this authorization. I am aware that certain State and Federal Statutes and Regulations require that I voluntarily and knowingly sign this document before the named agencies can release records and I may refuse to sign my signature, but in that event, the records cannot and will not be release or disclosed by the named individuals or agencies. I understand that I can discuss with legal counsel and the psychologist potential effects of signing or failure or refusal to sign to obtain records on the pending Court matter or evaluation. A photocopy or faxed copy of this authorization shall be deemed valid.

For Psychological/Psychiatric or Medical Clinics or Hospitals: This release covers and you are requested to send all available records, psychiatric history, mental status exams, results of psychological testing, copies to raw test data, behavioral observations, clinical notes, medical history, physical & neurological examination, drug screening laboratory findings, admission work up, discharge summary, nursing or interdisciplinary notes, physician notes, records obtained from other agencies, information regarding contacts & interactions with the above individual.

School, or Occupational Training Settings: This release covers and you are requested to send all available records, including grades, attendance records, behavioral data, health records, work assessments, supervisor reports, information regarding contacts and interactions with the above individual.

Re-disclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.

Date:_____ Signed: _____