

Susan Chakmakian, M.A., M.F.T.

Authorization to Release Confidential Information

I, _____ (“Patient”)

hereby authorize **Susan Chakmakian, MA, MFT** (“Provider”) to release confidential information obtained during the course of my treatment to:

 (“Recipient”).
(Name and Address of Recipient)

This Authorization permits the release of the following information:

- Diagnosis Treatment Plan Progress to Date
- Prognosis Clinical Test Results Dates of Treatment
- Any and All Information Necessary
- Other (specify) _____

I authorize the release of the information described above for the following purpose(s):

The specific uses and limitations on the types of information to be released are as follows:

The specific uses and limitations on the use of the information by Recipient are as follows:

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: ____/____/____ (“Expiration Date”)

By: _____ Date: _____
(Patient or Patient’s Representative)

620 West Arden Ave., Suite 401
Glendale, CA 91203

315 South Beverly Drive., Suite 307
Beverly Hills, CA 90212

(818) 754-4455