DONNA GOLD, LCSW
Psychotherapist Specializing in Trauma Survivors

Courage • Compassion • Connection

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, _____, herby authorize
(Print Full Name of Patient)

Donna Marie Gold, LCSW
11835 Carmel Mountain Road
Suite 1304, PMB 153
San Diego, CA 92128
Phone: (858) 227-9182
Fax: (858) 227-9477
Email: donnamgold@gmail.com

to release/exchange confidential information regarding my treatment to/with

Person / Agency / Provider: _____

Street Address: _____

City / State / Zip Code: _____

Phone: _____ Fax: _____ Email: _____

This authorization permits the release/exchange of the following information:

- ☐ Intake Information
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Prognosis
- ☐ Clinical Test Results
- ☐ Patient Records
- ☐ Summary of Treatment
- ☐ Discharge Summary
- ☐ Other: _____ (Please be specific.)

I authorize the release/exchange of information selected above for the following purposes:

- ☐ Coordination of Treatment
- ☐ Communication Between Treatment Providers
- ☐ Discharge Planning
- ☐ Other: _____ (Please be specific.)

This Authorization is valid from _____ (Today's date) until _____ (Typically, one year from today).

I understand I have a right to receive a copy of this Authorization. I also understand that I have the right to revoke this Authorization at any time.

_____ Patient Signature (if not a minor)

_____ Date

_____ Relationship to Patient

_____ Signature of Patient's Representative if Patient is a Minor or has a Conservator.

_____ Date

_____ Printed Name of Patient Representative