Authorization to Release Confidential Information
BETWEEN KAISER PERMANENTE AND EXTERNAL PROVIDER

I, (Name of Patient) _____hereby authorize (Name of Provider) **Deborah A. Lowe, PsyD, LMFT** to release confidential information obtained during the course of my treatment to (name and function of the person (s) to which information is to be released) **KAISER PERMANENTE**
MR#_____.

This Authorization permits the release of the following information:

_**X**__ Any and All Information necessary AND **EACH ONLINE ASSESSMENT**

☐ Diagnosis ☐ Treatment Plan ☐ Prognosis

☐ Progress to Date ☐ Clinical Test Results ☐ Dates of Treatment

☐ Patient Records ☐ Summary of Treatment ☐ Other: _____

I authorize the release of the information described above for the following purpose(s):
TO HELP PROVIDE APPROPRIATE MENTAL HEALTH SRVS

The recipient may use the information described above solely for the following purpose(s): **TO MONITOR MENTAL HEALTH SERVICES OF THE CLIENT**

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This Authorization shall remain valid until _____ (expiration date).

By: _____ Date: _____

(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her representative: _____.

By entering your typed name, you agree that the provided "e-signature" will be the electronic representation of your signature for the purposes of this document. You further understand your electronic signature will have the same legally binding effect assigning your signature using pen and paper. Submission of this signed and dated document shall evidence acceptance of your acknowledgement and consent.

SIGNATURE: _____ DATE: _____

(Patient/Parent/Conservator/Guardian)