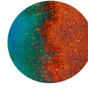
ROGERS FAMILY & SELF-CENTERED THERAPIES
"IT'S ALL ABOUT YOU, YOUR SELF & WHY. FROM YOUR POINT OF YOU.
TIMOTHY ROGERS, MA, LMFT
LICENSED PSYCHOTHERAPIST MFC101500
16133 VENTURA BLVD., ENCINO, CA 91436 (424) 239-8495



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME: ______________________________________DATE OF BIRTH: ______________

I HEREBY AUTHORIZE TIMOTHY ROGERS, M.A., L.M.F.T. (MFC101500) AND/OR STAFF MEMBERS OF ROGERS FAMILY THERAPY TO DISCUSS *PERTINENT CLINICAL INFORMATION WITH:

NAME: ____

ADDRESS: ____

PHONE: ____

EMAIL/FAX: ____

CONFIDENTIAL

FOR THE PURPOSE OF:

_____ CONTINUATION OF TREATMENT

_____ COORDINATION OF CARE

____APPLICATION FOR INSURANCE

_______LEGAL

____ OTHER (PLEASE SPECIFY) ____

____

____

CLIENT /LEGAL REPRESENTATIVE SIGNATURE

____

DATE

____

TIMOTHY ROGERS, MA, LMFT

____

DATE

"IT'S TIME TO LEARN HOW TO BECOME ATTRACTED TO WHAT'S HEALTHY."

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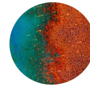

THE PURPOSE OF THIS DISCLOSURE AUTHORIZED HEREIN IS TO PROVIDE CONFIDENTIAL INFORMATION OF MY PSYCHOTHERAPY SESSIONS WITH TIMOTHY ROGERS, M.A., LMFT LICENSED MARRIAGE & FAMILY THERAPIST MFC#101500 TO PARTIES PROFESSIONALLY INTERESTED.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT FOR RELEASE OF INFORMATION AT ANY TIME. HOWEVER, I ALSO UNDERSTAND THAT ANY RELEASE WHICH HAS BEEN MADE PRIOR TO MY REVOCATION AND WHICH WAS MADE IN RELIANCE UPON THIS AUTHORIZATION SHALL NOT CONSTITUTE A BREACH OF RIGHT TO CONFIDENTIALITY.

I CERTIFY THAT THIS REQUEST HAS BEEN MADE FREELY, VOLUNTARILY AND WITHOUT COERCION. ANY OTHER USE OF THIS INFORMATION WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE CLIENT IS PROHIBITED.

CONFIDENTIAL

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL CONFIDENTIALITY REGULATIONS (42 CFR PART 2) PUBLISHED AUGUST 10, 1987, AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191), 42 U.S.C. SECTION 1320D, ET. SEQ AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT.

I UNDERSTAND THAT MY MEDICAL RECORD MAY CONTAIN INFORMATION CONCERNING MY PSYCHIATRIC, PSYCHOLOGICAL, DRUG OR ALCOHOL ABUSE, HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) AND/OR RELATED CONDITIONS.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME UPON VERBAL AND/OR WRITTEN NOTICE. I ACKNOWLEDGE THAT SUCH REVOCATION WILL NOT BE EFFECTIVE IF TIMOTHY ROGERS, MA, LMFT (MFC101500 HAS ALREADY ACTED IN RELIANCE UPON THIS AUTHORIZATION.

THIS AUTHORIZATION IS VALID (IF NOT PREVIOUSLY REVOKED) THIS CONSENT WILL TERMINATE UPON 365 DAYS FROM THE DATE OF THE SIGNATURE OF THIS FORM, OR THE FOLLOWING EVENT/ CONDITION: SHOULD THERAPIST & CLIENT FIND IT CLINICALLY APPROPRIATE DUE TO FAMILY DYNAMICS, OR THE COMPLETION OF TREATMENT, OR AT THE TIME OF THE FINAL INSURANCE BILLING, AS THE CASE MAY BE, WHICHEVER IS LATER.

REVOCATION DATE: ______________________