Cynthia Johnson-George, Ph.D.
Licensed Psychologist PSY 5894
(626) 244-7723

Authorization for Release of Information and Records

I have been informed that under California law communication between a patient and his/her psychotherapist are privileged and may not be disclosed by the psychotherapist unless the patient consents. I also have been informed that patient records maintained by a psychotherapist may not be disclosed to third parties except with the patient's consent or through the legal process.

I hereby authorize my therapist to disclose, release, and/or obtain records regarding

_____ _____ to/from:
(client name) (date of birth)

Check which individuals:

x	Primary therapist	Cynthia Johnson-George, Ph.D.
	Other therapists:	
	Pediatrician/physicians:	Dr. _____ Tel: _____ Dr. _____ Tel: _____
	My family member(s) as listed:	
	My lawyer:	
	The person who referred me:	
	My insurance company:	
	My social worker:	
	My child's school and/or teacher:	
	Other:	

This authorization is only for the limited purpose of releasing information to and discussing my case with these individuals or companies for the purposes of evaluation and treatment.

This authorization shall remain in effect for one year or until revoked by me in writing and will be considered no longer valid at the termination of treatment.

_____ _____
Signature Date