Dominique Samuels, PsyD.
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CONSENT TO RELEASE INFORMATION

By signing this document, I, (name of client) _____ (hereinafter "Client") hereby authorize _____ to release mental health treatment information and records obtained in the course of Provider's treatment of Client, including, but not limited to, Provider's diagnosis of Client, with:

▢ **By checking this box, I also authorize the exchange of information between these two parties.**

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Dominique Samuels, PsyD at 1833 Fillmore Street, Suite 102, San Francisco, CA 94115.

This disclosure of information and records authorized by Client is required for the following purpose:

Such disclosure shall be limited to the following specific types of information:

Provider shall not condition treatment upon Client signing this authorization.

Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California law.

This authorization shall remain valid until:

Client Signature (or Parent/Guardian Signature if under 18) Date