CINDY MAY, PH.D.

CLINICAL PSYCHOLOGIST ▪ PSY24260

AUTHORIZATION OF DISCLOSURE OF PATIENT INFORMATION

I authorize Cindy May, Ph.D. and

____

NAME OF PERSON, AGENCY OR INSTITUTION

____

ADDRESS

____

CITY STATE ZIP

____

PHONE FAX

To exchange information about:

____

NAME DATE OF BIRTH

Including, but not limited to medical records, lab results, psychological testing, medication records, school reports, etc. This information is to be used solely for the purpose of diagnostic evaluation and treatment or other:

____

This authorization shall become effective immediately and shall remain in effect until end of treatment. This consent is also subject to revocation by the undersigned at any time between now and the release of information by the sending person, agency, or institution.

____

PATIENT/PARENT/GUARDIAN Date

1101 DOVE STREET, SUITE 155 NEWPORT BEACH CA 92660 ▪ (949) 207-3447