Rebecca U. Romo, Psy.D.
Psychotherapy for Individuals and Couples
Clinical Psychology, PSY 17572

Authorization for Use or Disclosure of Personal Health Information

I, _____, give permission to Rebecca Romo, Psy.D. (PSY17572) to give and/or exchange necessary information regarding my case and treatment with the following person or agency:

_____
Name/Organization

_____
Address (Street Address, Apartment Number, City, State, Zip Code)

_____
Phone Number Fax Number

_____
Email

I agree to have the following information released (please initial option 1 or 2):

1. _____ any information necessary pertaining to my case and treatment.
2. _____ the information specified below:

_____

_____

_____

I understand 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 HIPAA Privacy Rule, although applicable California law may protect such information. I understand that I am granting permission for the extent of my treatment unless otherwise designated. I further understand that if, at any time, I desire to revoke this consent, I must do so in writing to the address listed below.

_____ _____

Client/Legal Guardian Signature Date

5242 Katella Ave., Ste 202, Los Alamitos, CA, 90720

P.O. Box 1405, Los Alamitos, CA, 90720

562.293.3095