LIGHT OF HOPE COUNSELING SERVICES, INC

Kiana Kalaghichian, LCSW
Business Address: 108 Orange Street, Suite 8, Redlands, CA 92373
1128 E. Sixth Ave, Suite 8, Corona, CA 92879
Phone: (951) 288-9086
Fax: (909) 363-8020

AUTHORIZATION TO EXHANGE COFIDENTIAL INFORMATION

I, (name of patient),_____, (hereinafter "Patient') hereby authorize, Kiana Kalaghichian, LCSW, (hereinafter "Provider") to exchange mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, with:
Name and Title:_____ ("Recipient")
Address_____
Telephone:_____ Fax:_____

_____ Entire File **_____ Psychotherapy Notes** **_____Session Start/Stop Times**

_____Diagnosis **_____ Treatment File** **_____ Symptoms**

_____ Prognosis **_____ Treatment Plan** **_____ Clinical Test Results**

_____ Modalities/Frequencies of Treatment Furnished **_____ Date of Treatment**

_____ Other _____

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 provider at :
108 Orange Street, Suite 8, Redlands, CA 92373
1128 E. Sixth Street, Suite 8, Corona, CA 92879 to be effective.

This disclosure of information and records authorized, by patient is required for the following purpose: _____

Further mental health care
Applying for insurance
At the request of the individual Payment of insurance claim Legal investigation Vocational rehab, evaluation Disability determination Other (specify): _____

I understand that information used or disclosed pursuant to this authorization may be subjected 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.
This authorization shall remain valid until:_____
Patient's signature: _____Date:_____
If signed by other than Patient, please indicate the relationship between Patient and Patient's Representative:_____

This Form was faxed to "Recipient" on _____by_____