Great Minds
THERAPY

Dr. Julia Kaluga, Psy.D., LMFT, LPCC
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
LMFT # 93579, LPCC # 3958
Info@GreatMindsTherapy.com
Tel: 323.304.5777

Authorization to Release Confidential Information

I, [Name of Patient] ______________________________________
hereby authorize [Name of Provider] ______________________________
to release confidential information obtained during the course of my treatment to the office of Dr. Julia Kaluga, Psy.D. LMFT #93579
This Authorization permits the release of the following information:

_________Diagnostic and/or treatment information
_________Clinical test results _________Medical reports
_________School reports _________Dates of Treatment
_________Other:_________________________________

This authorization shall become effective from___________ to ___________.
I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing. I understand that the information will not be used for any purpose other than its intended use.

Signed by: (Patient or Patient's Representative) _____________________________

Date____________

Great Minds Think Alike,
We Help Yours Heal and Thrive!