Biofeedback and Family Therapy Center
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RELEASE FORM

By signing this document, I, [Name of Patient or Guardian/Parent of Patient] _____ (hereinafter "Patient") hereby authorize Steven C. Kassel, MFT, BCB, BCN, AAPM (hereinafter "Professional") to disclose information and records obtained in the course of Professional's treatment of Patient, including, but not limited to, Professionals diagnosis of Patient, to [name and functions of the person or entity to whom disclosure is made]

_____

(Name, address, phone number, fax number of doctor, teacher, etc.)

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. I understanding that I have the right to revoke this authorization at any time unless Professional has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Professional at 26266 Prima Way, Santa Clarita, CA 91350 to be effective.

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

Please Circle: Diagnosis / Treatment / Other;_____

The specific uses and limitations on the types of medical information to be disclosed are as follows:

Please Circle: Diagnosis / Treatment / Other;_____

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

Please Circle: Diagnosis / /Treatment / Other;_____

Professional shall not condition treatment upon Patient signing this authorization. Patient has the right to not sign this form. Patient 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: _____ Patient Name _____

Signature: _____ Date: _____

Note Regarding This Fax: This packet contains confidential client records. These records are intended for the use of the individual or entity to which it is addressed and contains privileged, confidential information. If the reader of this message is not the intended recipient, pr the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of these records is strictly forbidden. If you have received this information in error, please notify me immediately at the above phone number or address via the U.S. Postal Service. The distribution of these records to the client is not recommended so as to reduce the possibility of misperception or inaccurate conclusions. It would be best understood if the client would discuss theserecords in person with the therapist.