Hessam Motamedian, PsyD. **Tel: (949) 342-5053 Fax: (949) 266-5619**

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CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

I, the undersigned, hereby consent to, direct and authorize Dr. Hessam Motamedian to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Hessam Motamedian and/or to the following person or agency:

_____ of _____
(Name) (Address and Telephone Number)

The information or records to be released or disclosed include:

_____ Initial Evaluation/History

_____ Psychiatric/Psychological Reports

_____ Medical Information

_____ Therapy Notes

_____ Billing Records

_____ Transfer/Termination Summary

_____ Tests Taken and Testing Scores

_____ Other (specify): _____

_____ Any and all records/Information

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Hessam Motamedian and his staff from any and all liability arising from release and disclosure of the information and records to the above named person.

_____ _____ _____
Client Name (Printed) Client Signature Date

_____ _____
Client Telephone Number Client Address

Witnessed by:

_____ _____ _____
Hessam Motamedian, Psy.D. (Or Printed Name of Witness) (Signature of Witness)