Leslie Spero, LCSW | LCS#26473
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Consent and Authorization to Use or Disclose Information

I, _____ (patient or guardian), hereby authorize Leslie Spero LCSW to disclose information and records obtained in the course of my psychotherapy treatment to:

_____

Name

_____

Address/City/State/Zip:

_____

Phone/Fax:

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of this authorization must be provided to me in writing and received by me at lesliesperoschneiderlcsw@gmail.com to be effective. I understand that I have the right to revoke this authorization at any time unless Leslie Spero LCSW had already taken action to cancel this authorization.

The purpose of information and records disclosure:

_____

The specific uses and limitations of the information to be disclosed:

_____

I understand that I have a right to refuse consent and signing of this authorization and Leslie Spero LCSW shall not condition my treatment with this refusal.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization remains valid for:
_____ 1-year from the date indicated below or ____ Terminated Date: _____
Signature of parent/ guardian: _____ Date: _____