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I authorize the use and/or disclosure of my protected health information (PHI) as contained in the portion of my clinical records that I have provided to Federico G. Anguiano:

Client: (Print): _____ DOB: _____

To: Recipient's name / phone / email _____

Recipient's relationship to the client _____

Purpose of release (***Mandatory***) _____

I authorize the disclosure of medical information, giving Federico G. Anguiano permission to disclose medical/mental health records and information obtained in the course of my therapy. This disclosure of medical / therapeutic information complies with the terms of the Confidentiality of Medical Information Act of 1981, California Civil Code section 56 ***et seq***.

I understand that the medical records/information to be released may contain information pertaining to my Somatic Experiencing treatment, counseling, coaching or health.

I authorize the disclosure of the following information: (Client must initial each box checked)

History and Physical Exam by other consultants _____ (initials)

Medication Records _____ (initials)

Client information _____ (initials)

Somatic Experiencing case discussion _____ (initials)

Other _____ (initials) Provide Description: _____

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize ***Federico G. Anguiano*** to disclose my health information. ***I may revoke this authorization at any time in writing.*** I have a right to receive a copy of this authorization. This authorization to release information will end one year from date signed.

_____ _____

Signature of Client Date