TRUST 2 BELIEVE | SOGOL PHILIPSON, LCSW

Coordination of Care — Limited Authorization

DRAFT — FOR CLINICIAN AND CALIFORNIA LEGAL/COMPLIANCE REVIEW

LCSW #66853 | 4199 Campus Drive, Suite 550, Irvine, CA 92612 | Telehealth only

People and purpose

I authorize Sogol Philipson, LCSW, to [ ] disclose to [ ] obtain from [ ] exchange with: _____ (provider / organization), contact information: _____.

Specific information

Information authorized: [ ] treatment dates [ ] diagnosis [ ] medications [ ] treatment summary [ ] other: _____. Purpose: [ ] coordinate treatment [ ] medication management [ ] other: _____.

Duration and revocation

Expiration date or event: _____. I may revoke this authorization in writing, except to the extent action has already been taken in reliance on it. Redisclosure by a recipient may not be protected by the same privacy laws.

Choice

I understand treatment is generally not conditioned on signing this optional authorization. Special protections may apply to certain records; obtain separate legally sufficient authorization when required.

Client name: _____ Date: _____

Client signature: _____ Date: _____