

**Paradigm Psychological Center
Esther Marron, Psy.D.
Licensed Psychologist PSY 21818
Authorization for Release of Medical/Mental Health Information**

I hereby authorize:

Name: Esther Marron, Psy.D.

Address: 12214 Riverside Drive
Studio, City, CA 91607

Phone: 310-808-5642 Fax: 310-407-8652 email: emarron@paradigmpsy.com

to obtain and release any medical, psychiatric, educational, psychological, or historical
information from and to:

Name: _____

Address: _____

Phone: _____ Fax: _____

email: _____

Concerning: _____
(Patient Name)

I understand that I may revoke this consent, in writing, at any time by informing any of the above noted individuals. All revocations must include the patient's name, address, and date of birth, the date of revocations, and the patient or patient's legal guardian's signature. All revocations must be sent to Esther Marron, Psy.D. and are not effective until received.

I hereby release the above parties from all liabilities arising there from. This consent, unless revoked in writing, is valid for one year from the date signed.

Please accept a photocopy of this authorization as if it were an original executed authorization.

Patient/Parent/Guardian's Signature: _____ Date: _____

Print Name: _____ Date: _____