GABOR VARI, M.D.
11980 SAN VICENTE BOULEVARD, SUITE 810
LOS ANGELES, CA 90049
310-820-3200
FAX 310-882-6528

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I,_____or_____
Name of Patient Date of Birth Name of Parent/Guardian/Conservator

Hereby authorize Gabor Vari, M.D. to release medical information with the knowledge that this contract discloses the fact that mental health services have been/are being provided. This information will be provided to:

_____
Name Telephone Number
_____
Address
_____

Patient information may also be released vice versa from the person referred to above and to Gabor Vari, MD. Release or transfer of the disclosed information, by other than patient or parent/guardian, conservator named, to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information. **This authorization shall remain valid until treatment ends.**

I understand that I have the right to receive a copy of this authorization.

_____or_____
Signature of Patient Date Signature of Parent/Guardian, Conservator Date

_____ _____
Witness to above Signature Relationship to Patient