OCEANSIDE PSYCHOLOGY CLINIC

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize:
Person or facility:_____
Address: _____ Phone: _____
_____

to exchange information from records about _____, born on _____,
with:

Person or facility:_____
Address: _____ Phone: _____
_____

for the following purpose(s):

□ Further mental health evaluation, treatment, or care
□ Treatment planning
□ Other: _____

These records concern the time between _____ and _____.

The information to be disclosed is marked by an X in the boxes below:

□ Medical history and evaluation(s)
□ Mental health evaluations
□ Developmental and/or social history
□ Educational records
□ Progress notes, and treatment or closing summary
□ Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

_____	_____	_____
Signature of client	Printed name	Date