Authorization of Release of Information

Pursuant to the Confidentiality of Medical Information Act, as amended, California Civil Code 56 et seq.

Client Name _____ Phone _____ Date of Birth ___/___/___

I, _____ hereby authorize the release and
(Print Client Name)

disclosure of the following clinical and/or therapeutic records for the following Purpose (s):

- □ Authorization to release information regarding counseling and psychotherapy care and treatment.
- □ Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.
- □ Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release authorized information between:

Roberta (Bobbi) Thomas, LMFT
527 E. Rowland St. Suite 112
Covina, CA 91723
626 598 3379

and _____

_____

(Recipient Name, Address, Agency and Phone No.)

Specific information to be released:

□ Intake & Assessment	□ Entire File	□ Psychiatric Evaluation
□ Dates of Treatment	□ Presenting Symptoms	□ Psychological Testing Report
□ Discharge Plans	□ Prognosis	□ Treatment Plans & Recommendations
□ Diagnosis	□ Progress to Date	□ Other _____
□ Inform Referral Source of Client Contact		

Purpose(s) for which information is to be released:

□ Continuity of Care □ Other _____

This Authorization becomes effective on the date signed and will **automatically expire after a period of 2 years from the dated signed**. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

Client Signature: _____ Date _____

Parent/Guardian Signature if client is a minor: _____ Date _____