

# 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:

Robin Thomas, LCSW  
527 E Rowland St, Ste 112  
Covina, CA 91723  
626 598 3715

and \_\_\_\_\_

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

## Specific information to be released:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Intake & Assessment | <input type="checkbox"/> Entire File         | <input type="checkbox"/> Psychiatric Evaluation            |
| <input type="checkbox"/> Dates of Treatment  | <input type="checkbox"/> Presenting Symptoms | <input type="checkbox"/> Psychological Testing Report      |
| <input type="checkbox"/> Discharge Plans     | <input type="checkbox"/> Prognosis           | <input type="checkbox"/> Treatment Plans & Recommendations |
| <input type="checkbox"/> Diagnosis           | <input type="checkbox"/> Progress to Date    | <input type="checkbox"/> Other _____                       |

## 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 \_\_\_\_\_