



Authorization of Release and/or Exchange 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/or exchange of confidential information between:

Name: _____

Center for Individual and Family Therapy
1633 E Fourth St, Suite 120, Santa Ana, CA 92701
714-558-9266 x_____

and _____

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

Specific information to be released:

- | | |
|--|--|
| <input type="checkbox"/> Any and All Information Necessary | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Client Records | <input type="checkbox"/> Treatment Plans & Recommendations |
| <input type="checkbox"/> Dates of Treatment | <input type="checkbox"/> Psychological Testing Report |
| <input type="checkbox"/> Discharge Plans | <input type="checkbox"/> Progress to Date |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Other Use/Limitation: _____ |
| <input type="checkbox"/> Psychiatric Evaluation | _____ |
| <input type="checkbox"/> Presenting Symptoms | _____ |

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

- Continuity of Care
- Other: _____

This Authorization becomes effective on the date signed and will remain valid until _____ ("Expiration Date"). I understand that this information may not be released to any other organization without my permission. A photocopy of this authorization shall be considered valid. I understand that I have a right to receive a copy of this Authorization. I also understand that any cancellation or modification of this authorization must be in writing.

By: _____ Date _____
(Client or Client's Representative*)

**If signed by other than Client, please indicate the relationship between Client and his/her Representative: _____*