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:

- ❑ Any and All Information Necessary
- ❑ Client Records
- ❑ Dates of Treatment
- ❑ Discharge Plans
- ❑ Diagnosis
- ❑ Psychiatric Evaluation
- ❑ Presenting Symptoms
- ❑ Prognosis
- ❑ Treatment Plans & Recommendations
- ❑ Psychological Testing Report
- ❑ Progress to Date
- ❑ Other Use/Limitation:

_____

_____

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:* _____