Cardiff Counseling Center

Individual, Couples & Family Therapy
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Locations in Cardiff & San Diego
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Authorization to Release Confidential Information

I, [Name of Patient] _____("Patient") hereby authorize [Name of Provider]_____ ("Provider") to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] _____("Recipient").

THIS AUTHORIZATION PERMITS THE RELEASE OF THE FOLLOWING INFORMATION:

____ Diagnosis ____ Treatment Plan ____ Progress to Date

____ Prognosis ____ Clinical Test Results ____ Dates of Treatment

____ Any and All Information Necessary ____ Other (specify)

I authorize the release of the information described above for the following purpose(s):

_____

_____

The specific uses and limitations on the types of information to be released are as follows:

_____

_____

The specific uses and limitations on the use of the information by Recipient are as follows:

_____

_____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____ ("Expiration Date")

By: (Patient or Patient's Representative): _____ Date:_____/_____/_____