AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I,_______________________________________________________________________,
Address and Phone_____________________________________________________________________

Authorize: Center for Mental Wellness
PO Box 1112, Cardiff, CA 92007
Phone: 858-461-9409 Email: info@socalmentalwellness.com

To ( ) Obtain
( ) Release:

( ) Treatment Summary
( ) Psychological Evaluation/Testing
( ) Treatment Plan and/or Progress
( ) Other:
( ) Discharge Summary
( ) HIV and/or Drug/Alcohol Abuse/Addiction
( ) Consultation

From/To the following:

Name:

Address:

Phone:

I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein. Further, this release will remain in force throughout treatment.

If client is a minor:

| | |
|---|---|
| Child's name: | |
| Name of parent or client's representative (please print): | |
| Signature of parent or client's representative: | |
| Date of signing: | |

If client is over 18 years old:

| | |
|---|---|
| Name (please print): | |
| Signature of client | |
| Date of signing: | |