AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION TO RELEASE, TO REQUEST OR TO DISCLOSE INFORMATION IS TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 56 ET SEQ., CA CIVIL CODE.

_____ _____/_____/_____

Patient Name D.O.B

_____

Address City/State/Zip

I hereby authorize the release of information:

☐ TO AND FROM ☐ TO ☐ FROM _____

Affiliated Psychological Services
7293 Dumosa Ave Suite 8
Yucca Valley, CA 92284
760-369-7166
Fax # 760-369-7167

Name: _____ Relationship or title_____

Address_____Phone_____

For ___Coordination of Care ___Disability Evaluation ___Other_____

_____

Limits on information disclosure: ☐ None ☐ Limit to _____

I understand that I can receive a copy of this authorization upon my request. This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on: _____.

(Date, or terms)

_____ _____

Signature of Patient (Parent/Guardian/Conservator) Date

_____ _____

Signature of Therapist Date