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|  | **Laura Dickson, LCSW • Jennifer Duke, LMFT • Sara Lee, LLCSW** |

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# Consent to Release Information from Medical Records

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| Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| I request and authorize (*circle one:* **Laura Dickson, LCSW ; Jennifer Duke, LMFT ; Sara Lee, LCSW**) to disclose information from my health records which were obtained during my diagnosis and treatment to: | [Name] :  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   [Street address]:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  [City, ST ZIP Code]:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**The disclosure of these records are required for the purpose of:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The disclosure is limited to the following specific types of information:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This consent will become effective immediately. If it is not revoked earlier, it will remain in effect for ONE YEAR from the date of signature.**

**I am fully aware that certain State and Federal Regulations protect the confidentiality of the information in these records. These regulations also require that I voluntarily sign this document before any release of records, and I may refuse to sign my signature, in which event the records cannot and will not be released by this office.**

**This consent includes all records of medical, psychiatric, and/or substance abuse diagnoses, examinations, treatments, prognosis, counseling and/or therapy which may be subject to the confidentiality requirement of Section 5328 of the California Welfare and Institutions Code and/or 42 C.F.R., Part 2, Federal Register.**

**Signature of Patient**

**Date**

**Signature of Parent/Legal Guardian**

**Date**