glendale
counseling services

David Ibrahim, M.A., LMFT, CADC II

100 North Brand Blvd., Suite 412 | Glendale, CA 91203
Phone: **(323) 533-8805** | www.GlendaleCounselingServices.com

Consent to Release Information from Medical Records

Patient's Name: _____

I request and authorize **David Ibrahim, M.A., LMFT, CADC II** to disclose information from my health records which were obtained during my diagnosis and treatment or coaching session to:	[Name] : _____ [Street address]: _____ [City, ST ZIP Code]: _____

The disclosure of these records is 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.

_____ _____

Date **Signature of Patient**

_____ _____

Date **Signature of Parent/Legal Guardian**