

# Authorization for Release of Information



**California Therapy Center**  
& Psychological Services, Inc.

1101 N. Pacific Ave., Suite 204 | Glendale, CA 91202

Tel: 818-396-5343 | Fax: 818-561-3997 | caltherapycenter@gmail.com

1. Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_
  
2. Information to be released :
  - Summary of treatment to date
  - Report
  - Other: \_\_\_\_\_
  
3. Purpose of Disclosure
  - Coordination of Care
  - Other: \_\_\_\_\_
  
4. Persons authorized to make Disclosure:  
\_\_\_\_\_
  
5. Person authorized to receive Disclosure:  
\_\_\_\_\_
  
6. Method of Disclosure
  - Written : \_\_\_\_\_
  - Verbal: \_\_\_\_\_
  - Electronic: \_\_\_\_\_
  
7. Today's date: \_\_\_\_\_ Authorization to expire on: \_\_\_\_\_

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_