Family Therapy Institute of Santa Barbara

Name of Therapist: _____License No._____

Authorization to Release Medical Information

By signing this document, I, _____, hereby authorize
(Name of client and/or parent or legal guardian if minor)

The Family Therapy Institute to disclose to and/or obtain information from:
_____ about myself and/or my minor child.
(Name of person or entity receiving records) (Circle one or both).

I authorize the above to exchange mental health records and information obtained during the course of treatment. I understand that I have a right to receive a copy of this authorization. The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purposes, please specify:

_____

_____

I agree that the following information may be disclosed:

_____**Any or all of the following**

_____Medication management information

_____Assessment

_____Diagnosis

_____Psychosocial Evaluation

_____Psychiatric Evaluation

_____Treatment plan or summary

_____Current treatment update

_____Medical Information

_____Educational/testing information

_____Discharge/transfer summary

_____Progress in treatment

_____Demographic information

_____Financial/billing information

_____Other:_____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Family Therapy Institute. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on this authorization.

Unless sooner revoked, this consent expires one year from the date signed below.

_____

Signature of Patient/Client or Parent/Legal guardian Date