Family Therapy Institute of Santa Barbara

Name of Therapist: ___________________________ **License No.**__________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I acknowledge that my typed initials/name below each statement is legally binding and represents my full agreement to the terms within each statement that I provide my initials or name. _______ (*initial*)

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) (check 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:

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I agree that the following information may be disclosed:

_____ **Any or all of the following:**
_____ Medication management information
_____ Assessment
_____ Educational/testing information
_____ Diagnosis
_____ Discharge/transfer summary
_____ Psychosocial Evaluation
_____ Progress in treatment
_____ Psychiatric Evaluation
_____ Demographic information
_____ Treatment plan or summary
_____ Financial/billing information
_____ Current treatment update
_____ Medical 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

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