Dr Jennifer Cory
PSY20743
619 S. Vulcan Ave. #103
Encinitas, CA. 92024

Authorization for Release of Protected Health Information

I, _____, _____, hereby give
Client Date of Birth

permission to _____ (treating psychotherapist) to:

_____ **Disclose** and/or _____ **Obtain** information from:

_____
Name

_____
Address

Phone: ( ) _____ Fax: ( ) _____

Information to be disclosed/obtained:

____ My entire Medical Health Record or ____ My entire Substance Abuse Record

____ Only the following information:

_____ Substance Abuse _____ Progress Report

_____ Diagnosis/Assessment _____ Treatment Recommendations

_____ Other (specify) _____

Form in which information should be released:

_____ Verbal _____ Written _____ Photocopied _____Other _____

Purpose for Disclosure:

_____ Continuity of Care _____ Case Management _____ Other _____

I may revoke this consent at any time by written request, except to the extent where action has already been taken. Without such revocation this consent will automatically expire one year from the date of my signature.

_____ _____
Signature of Client Signature of Parent or Guardian

_____ _____
Date Witnessed by