Orange County Psychotherapy Associates, Inc.

Consent to Release Confidential Information

I hereby authorize ____
(Name)

____
(Address)

to disclose records of ____
(Name)

____
(Address)

These records having been obtained in the course of diagnosis and treatment or other professional relationships. Send these records to:

____
(Name)

____
(Address)

This disclosure of records authorized herein is required for the following purposes:

____, and such disclosure shall be limited to the following specific to revocation by the undersigned at any time except to the extent that action has been taken in reliance and if not earlier revoked, it shall terminate on:

____
(Date, event or condition on which consent will terminate)

____
(Signature of Patient)

____
(Signature of Authorized person if patient is a minor)

____
(Date)

Note: Federal regulation requires that all blanks must be completed including date, event or condition on which consent terminates. Refer also to State of California, Welfare and Institution Code, Division 5, #5327 and #5328, releasable under Public Law 93-579.