Authorization to Release Information

Federal law requires your specific authorization for release to appropriate parties any information about your or your child's treatment for certain conditions. Please check and sign all pertinent statements below giving your permission to communicate with the following individual, agency, school or organization on your or your child's behalf

Client Name:_____ DOB:_____

I hereby authorize: Emily Merryweather, M.A., NCC, LPCC Phone: (760) 783-5583

12625 High Bluff Drive, Suite 104, San Diego, CA 92130 Fax: (877) 720-9488

To: Disclose to Obtain from Fax E-mail

The following individual, agency, school or organization:

_____

_____

Address City State Zip code

_____

Phone Fax E-mail

The following information:

- History & background
- Summary report
- Service/treatment plan
- Psychosocial evaluation
- Psychological evaluation/testing
- Psychiatric evaluation
- Consultation report
- Laboratory work and Test results
- Other (specify) _____

The information is required for:

- Diagnostic assessment
- Planning services
- Coordination/collaboration of client's care
- Planning treatment
- Other (specify) _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization become effective _____ and will expire one year from the date of signing, if not earlier revoked. I have been informed what information will be exchanged, its purpose, and who will receive the information. I am aware that such contact discloses the fact that mental health services have been/are being provided.