Torrey Hills Health

Authorization for Release of Information

I (We) authorize Angela L. Phillips, M.A., M.F.T., to release and disclose from the clinical record of:

_____ _____
Name of client/recipient of mental health services Date of birth

I allow such information to be inspected and copied by:

_____
Facility/Provider

_____
Address

_____
State specific nature of information to be disclosed

_____
State specific purpose of information to be disclosed

This information is hereby released to the above named therapist/facility for the purposes of facilitating counseling/consultation, and/or conducting an evaluation.

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to the above named therapist/facility. I understand that a revocation is not valid to the extent that the above named therapist/facility has acted in reliance on such authorization. It is your right to obtain a copy of this authorization.

This authorization is valid until _____.
Date

A copy of this release shall have the same force and effect as the original.

_____ _____
Client Signature (12 yrs. or older) Date Parent/Guardian Signature Date

_____ _____
Witness Date Relationship

NOTICE TO RECEIVING FACILITY/THERAPIST:

You may not disclose any of this information unless the person who consented to this disclosure specifically consents to such disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.