

Torrey Hills Health

Authorization for Release of Information

Name of client/recipient of mental health services

Date of birth

I (We) authorize named Facility/Provider below to release information that is listed below

Facility/Provider

Address

State specific nature of information to be disclosed

This information is hereby released to **Angela L. Phillips, M.A., M.F.T.**, 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 **Angela L. Phillips**. I understand that a revocation is not valid to the extent that **Angela L. Phillips** 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.