

# COGNITIVE THERAPY AND CONSULTING ASSOCIATES

151 KALMUS DRIVE, SUITE B/220 • COSTA MESA, CA 92626 • (949) 675-0545 • FAX (714) 437- 1687 • WWW.PSYHEALTH.NET

## Authorization For Release of Information

I authorize:

Name (s): \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Office telephone: \_\_\_\_\_

Office fax: \_\_\_\_\_

to release information and/or records regarding my treatment to:

( <-Printed name of provider )

Cognitive Therapy and Consulting Associates (CTCA)

151 Kalmus Drive, Suite B/220

Costa Mesa, CA 92626 949 675 0545 Fax 949 437 1687

I understand I have the right to limit the type of information released. If I choose to limit the information released, I understand that it may be necessary CTCA to inform the requestor that portions of the record have been withheld.

Unless otherwise indicated below, my signature authorizes release of all records without exception.

This consent is subject to written revocation by the undersigned at any time except to the extent action has been taken, and if not revoked earlier, this consent shall become invalid six months from the date of signature.

I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

I understand I have a right to receive a copy of this Authorization, if requested.

A photocopy, digital copy or facsimile of this Authorization shall be as valid as the original.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CTCA Provider Signature

\_\_\_\_\_  
Date