

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 To Release Information

I authorize _____ (<-Printed name of provider)
Cognitive Therapy and Consulting Associates (CTCA)
151 Kalmus Drive, Suite B/220
Costa Mesa, CA 92626

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

Name (s): _____
Address: _____
Address: _____
Office telephone: _____
Office fax: _____

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