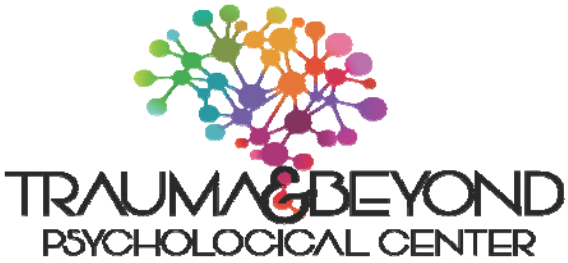


4419 Van Nuys Blvd. #206 Sherman Oaks, CA 91403
818-351-3511

Consent to Release/Receive Confidential Information

By signing this document, I, _____ hereby authorize
(Print Name)

_____ to disclose/receive information on _____
(Patient's Name)

Obtained in the course of diagnosis and/or treatment to:

_____
(Name of Person/entity to receivce/disclosure information to and from)

_____
(Telephone / Fax)

I also understand that any cancellation or modification of this authorization must be in writing.

This disclosure of information and records authorized herein is required for the following purpose:

Education	Legal	Psychiatric	Psychological
Insurance	Medical	Psychometric Testing	Information for Payment Purposes

Other: If therapist believes that client is out of control, not meeting qualifications for hospitalization but out of control .

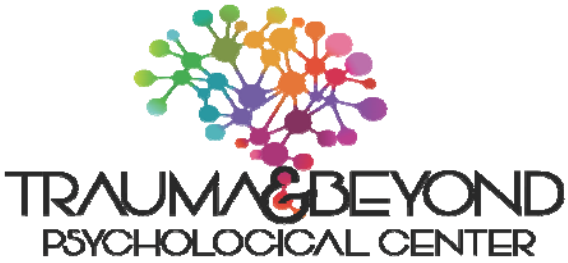
The specific uses and limitations on the types of medical information to be disclosed are as follows:

The authorization should remain valid until: _____

I understand that this information may not be released to any other person or organization with my permission in writing. A photocopy of this authorization shall be considered valid. The information disclosed shall not be used for any purpose other than its intended use. The party requesting this information will destroy or will return the information immediately after the length of time specified, unless the patient has signed a waiver.

Signature of:	Patient	Parent	Guardian

Signature:_____ Date:_____



4419 Van Nuys Blvd. #206 Sherman Oaks, CA 91403
818-351-3511

Address: _____

DOB:_____

Telephone: _____