211 S. Primrose Ave.
Monrovia CA 91016
(626) 359-4330

Consent to Release Information

Client Name:_____

Parent/Guardian (if applicable):_____

Information to be released:

- ❑ Dates of treatment
- ❑ Diagnosis
- ❑ Clinical test results
- ❑ Patient record
- ❑ Prognosis
- ❑ Progress to date
- ❑ Summary of treatment
- ❑ Treatment Plan
- ❑ Other (describe below)

_____

_____

Reason for release:

_____

_____

Release to:

Name:

_____

Address:

_____

Phone and/or Fax:

211 S. Primrose Ave.
Monrovia CA 91016
(626) 359-4330

Email:

This release to expire on the following date:

I understand that my records are confidential information and by signing this agreement only the above described information will be released to the identified party. I have the right to revoke this agreement at any time and this revocation must be submitted in writing.

I understand that I have the right to receive a copy of this authorization.

Client Signature **Date**

Parent/Guardian Signature (if applicable) **Date**