



SAMARITAN COUNSELING CENTER

Serving Individuals, Couples, and Families since 1973

Doug McKown, Psy.D., Executive Director

CONSENT FOR RELEASE OF INFORMATION OR RECORDS

This Release is regarding _____ DOB: ___/___/___

Clients Name (print)

A. TO ANOTHER PROFESSIONAL OR AGENCY:

I hereby authorize the Samaritan Counseling Center to release information/records regarding the above named client to:

Address

Phone Number

B: TO THIS CENTER:

I hereby authorize _____

Name of professional or agency

To release information/records regarding the above named client to the Samaritan Counseling Center, 1126 W Foothill Blvd., Suite 110, Upland, CA 91786.

C: PURPOSES:

These records are all protected by the California Welfare and Institution Code, Section 5328. Disclosure shall be limited to the information specified below:

Check appropriate items

Diagnosis

Psychological assessment/evaluation

Treatment summary

Progress notes

Verification of Attendance

Other:

D. DATES:

This authorization shall become effective on ___/___/___

The consent shall terminate on ___/___/___

Note: Unless otherwise stated, this authorization will terminate automatically, one year from the effective date. You also have the right to revoke in writing this authorization at any time. (Except invoice and contract monitoring does not expire)

SIGNATURES:

_____/_____/_____

Date

Client Name (Print)

Witness

Signature Client or Parent/Guardian
(Indicate relationship if client is a minor)