Authorization for Release of Protected Health Information

I, _____, whose Date of Birth is _____,

authorize Alicia Outcalt, LCSW to disclose to and/or obtain from:

_____ the following information:

Please initial any item(s) to be disclosed

_____Any health, mental health and substance use information including treatment

_____Mental Health information

_____Participation in Treatment

_____Other:_____

Purpose:

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:_____

Revocation:

I have a right to revoke this authorization, in writing, at any time by sending written notification to Alicia Outcalt at 3990 Old Town Avenue C203, San Diego, Ca 92110.

Expiration: Unless sooner revoked,

Please initial one _____This consent expires at termination of this treatment

OR _____This consent expires on: _____

I understand that Alicia Outcalt, LCSW will not condition my treatment on whether I give authorization for the requested disclosure.

_____

Signature of Patient Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).