



## **Authorization to Release Information**

I / We hereby authorize, **San Diego Family Services**, located at 1104 Camino Del Mar, Del Mar, CA 92014, to exchange and/or release information gathered by the clinician visited as part of an evaluation, psychological services, and/or custody evaluation. The purpose of the release is to:

\_\_\_\_\_ and affects  
the patient(s) named: \_\_\_\_\_.

The question of privacy between the institution, agency, school, the attending physician or physicians, mental health clinicians, attorneys, judges, and courts, to which the information is shared, is hereby waived. I understand that this waiver includes any local, state, or federal laws governing the privacy of such information, including, but not limited to, the Health Insurance Portability Accountability Act (1996) and the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code, and any subsequent revisions to either. This authority extends to the furnishing of copies of all or any desired parts of records used to complete a Psychological Services Examination, Mental Health Therapy Session(s), and/or Child Custody Evaluation.

**I understand that the medical records and information to be released may contain information pertaining to a psychiatric, drug and/or alcohol related evaluation and/or treatment, and may also contain confidential HIV (AIDS) related information, including educational, psychological, and laboratory test results.**

San Diego Family Services, their staff, and clinicians, are hereby released from all legal liability that may arise from the release of the information requested. Please note the following are exceptions to this release of information:

\_\_\_\_\_

I may revoke this authorization at any time, in writing, before the information has been released. This Authorization automatically expires six (6) months from the date of signature unless otherwise revoked. If the person(s) signing is doing so as the parent or guardian of the patient, please indicate as such. If both parents share equal custody, then both must sign. If an adult is unable to sign for themselves, please indicate why:

\_\_\_\_\_

I agree that a photocopy or facsimile of this authorization is to be considered as effective as the original. In addition, the transmittal of the requested information will be made either by email, facsimile, or US Postal, at the discretion of San Diego Family Services.

I/we understand the above and anything that may not have been clear to me/us has been explained. I/we am/are authorized to sign this release on behalf of the patient(s) and no other person is required or necessary to sign.

Patient/Client:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: Self / Parent / Spouse

Patient/Client:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: Self / Parent / Spouse

Therapist/Authorized Representative:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_