Claremont Counseling and Support Center
Authorization to Release Confidential Information

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909-624-1997   909-624-4409 fax

I, (name if client) ____

SS# ________________________   DOB ____________________

hereby authorize the following parties to release/share confidential information obtained during the course of my treatment to one another:

____

Name   Title/Relationship   Phone

____

Name   Title/Relationship   Phone

This authorization permit's the release of the following information:

____ Any and All Information Necessary

____ Treatment Plan   ____ Diagnosis   ____ Prognosis
____ Progress to Date   ____ Clinical Test Results
____ Dates of Treatment   ____ Patient Records
____ Summary of Treatment   Other _____________________

I authorize the release of the information described above for the following purpose(s):

____

I understand that I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be made in writing.

This Authorization shall remain valid until: __________ (Exp. Date)

_____________________________________   _________

Signature of Client or *Client's Representative   Date

*** If signed by other than Client, please indicate the relationship between Client and his/her Representative: ___________________________________**

The client has the right to a copy of this release.***