Transcend Therapy, Inc.

Authorization to Release Confidential Information

Client Name: ______________________________ **Date of Birth:** _______________

I hereby authorize the two-way disclosure and/or two-way exchange of client's health information as follows between:

Transcend Therapy AND ___________________________________

Person/Agency Name *Person/Agency Name*

__4452 Park Blvd. Ste. 204,
San Diego, CA 92116
__7183 Navajo Rd. Ste. B,
San Diego, CA 92119

____

Address *Address*

619-823-1382 / 888-618-3258

____

Phone/Fax Number *Phone/Fax Number*

PURPOSE FOR AUTHORIZING THE DISCLOSURE OF MY HEALTH INFORMATION:

___Evaluation ___Treatment Planning/Course ___Other: ___________________

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION: (Please have client/legal rep initial next to each selection)

	Entire Record		Psychological Testing Results
	Diagnosis		Social History
	Psychiatric Evaluation		Academic/School
	Individual Treatment Plan		Discharge Summary/Aftercare Plan
	Substance Abuse History/Treatment		Other:

EXPIRATION This authorization expires on: ___________________________________

SIGNATURE

I have read and understand the terms of this authorization to release information. I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

Signature: ____ **Date:** _________________

*If the client is a minor, parent or legal representative must sign below and indicate relationship to client.

Signature: ____ **Date:** _________________

Name and Relationship: ____