Assessments • Consultation • Counseling

Authorization for Information to be Disclosed to Parents
(For Clients Over 18 Yrs. Of Age)

Completion of this document authorizes the disclosure of individually identifiable health information, as set forth below, consistent with California and Federal Law concerning the privacy of such information.

Client Name:____Birth date: ___________________

Maiden or other preferred name (if applicable): _____________________________________

I request and authorize Summit Center staff____to release the health care information described below to:

Name:____phone number: _________________________

Please initial to specifically authorize the use and/or disclosure of:

____ Billing/Payment Information

____ Appointment Information (scheduling, cancellations, and rescheduling)

____ Verbal Discussion of Case

____ Clinical Notes

____ Intake Forms (i.e Parent Questionnaire, etc)

____ Assessment Results

____ Other (specify):________________________________

The requested records or information is about health care provided during the following approximate time frame:

____

Authorization expires: ____

I understand that I may rescind this consent at any time through written request stating that I do not give permission for further release or disclosure of information.

Date:_____________ Client/Authorized Representative ____

(Signature)