Addiction & Mental Health Counseling of San Diego
11417 West Bernardo Ct., Suite K
San Diego, CA 92127
(858) 254-4192

Authorization to Release Confidential Information to Family Members

Name of client: _____

Date of birth: _____

I understand that the purpose of this release is to assist with my/this client's counseling by improving communication between professional service providers or agencies and the important individual(s) in my/the client's life. To further this goal, I authorize this specific service provider to release the below-specified information regarding me/the client to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality, and I accept these.

The information to be disclosed is marked by an × in the boxes below:

☐ Name of psychologist ☐ Name of agency ☐ Diagnosis ☐ Scheduled appointments

☐ Admission/discharge information ☐ Counseling plan ☐ Attendance

☐ Compliance and participation ☐ Discharge plans ☐ Counseling summary

☐ Other: _____

This information is to be disclosed to these persons, who have the indicated relationship to me/ the client:

Name of person: _____ Relationship:_____

Name of person: _____ Relationship:_____

Name of person: _____ Relationship:_____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire on ◉ 1 year from this date, ○ upon my discharge from counseling by this agency or by the person specified above, or ○ under these circumstances: _____.

Signature of client: _____

Printed name: _____

Date: _____

(For minors) Signature of parent/guardian: _____

Printed name: _____

Relationship: _____

Date: _____

Signature of psychologist:_____

Printed name: _____

Date: _____