Addic! on & Mental Heal" Counseling of San Diego

11417 West Bernardo Ct., Sui# K

San Diego, CA 92127

$858% 254-4192

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name: ________________________

By signing this document, I, hereby authorize psychologists with Addiction and Mental Health Counseling of San Diego to disclose information and records on **myself** (other:____________________) obtained in the course of diagnosis and/or treatment to:

Name/Agency: __________________________

Address: _______________________________

City & Zip: _____________________________

Telephone: _____________________________

I understand that any cancellation or modification of this authorization must be in writing. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.
I give permission to psychologists with Addiction and Mental Health Counseling of San Diego and the agency/person listed above to share the following information:

____ All psychological information

____ Limited to (specify): ____

____
Print name

____________________________ ________________
Signature of Client (or Parent) Date