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

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

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, School, or Individual:

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:

_____Educational
_____Medical
_____Psychological
_____Psychometric (testing)
_____Social
_____ Psychiatric

_____ _____
Signature of Client/Parent/Guardian Date