

Hollywood Psychology Center

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Consent for Disclosure of Information

I (name of client/patient), _____
for minor (name of minor client/patient) _____ authorize only
(name(s) of service provider(s), agency or institution) _____ to disclose/receive solely
to/from Hollywood Psychology Center for the purpose of (treatment, referral, consultation, testing, psychological evaluation etc):

_____ the following information regarding my diagnosis and treatment (including information, if any, regarding substance abuse treatment and/or mental health treatment), the confidentiality of which is protected by federal and/or state law (case notes, social and/or psychological history, diagnostic impression, test results and reports, letters, consult reports, medical history and physical report, etc.):

I understand that I have the right to inspect and copy any written information which is disclosed. I understand that if I do not consent, no information will be disclosed except as provided by law.

This consent is subject to revocation in writing at any time, but such revocation can have no effect on disclosures previously made. In any event, this authorization expires without express revocation upon termination of therapy or on the date indicated below.

Release expiration date _____

Signature of client (or parent/guardian) _____

Date _____

Signature of witness _____

Date _____