PSYCHSTRATEGIES

Authorization to Release Information

I hereby authorize PsychStrategies and PsychStrategies Providers to disclose my medical record to the person or entity listed below. I understand that the record may contain protected information and consent to the release of (specify):

___ Psychotherapy notes ___ Medication evaluations

___Psychiatric evaluation ___ Other (specify):

Patient Name: _____ Date of Birth: _____
(Please print)
Address: _____Phone:_____

Records to be released to:

Name: _____

Address: _____

Phone: _____

Fax: _____ (If applicable.)

Signature: _____ Date: _____
(Client/legal guardian/legally authorized representative of client)

Person completing form if other than patient:_____

This authorization will remain in effect for 1 year unless stipulated below:

Effective Date:_____ End Date:_____

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Santa Rosa, CA 95404
707-526-8300
707-526-8310 Fax

1330 N Dutton Avenue #100
Santa Rosa, CA 95401
707-526-8309
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