



## 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                      \_\_\_ Progress Notes  
\_\_\_ Psychiatric evaluation                      \_\_\_ Other (specify):

---

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please print)  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Records to be released to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ (If applicable.)

For the purpose of: \_\_\_\_\_

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:** \_\_\_\_\_

659 Cherry Street  
Santa Rosa, CA 95404  
707-526-8300  
707-526-8310 Fax

1160 N. Dutton Avenue #230  
Santa Rosa, CA 95401  
707-526-8300  
707-526-8319 Fax

25 Western Avenue  
Petaluma, CA 94952  
707-776-0945  
707-776-0935 Fax

[www.psychstrategies.com](http://www.psychstrategies.com)