Castillo Psychological, LLC

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RELEASE OF INFORMATION

Name of Client: _____ **Date of Birth:** _____

Social Security Number: _____

I authorize the following provider(s) to release or request the following documents:

☐ Janette Castillo, Ph.D. ☐ Joe Castillo, LCSW ☐ Brooks Strawn, LMSW

☐ Brianna Kocon, LPCC ☐ Angelo Cordova, LMSW ☐ All Providers

I authorize the following documents to be released: ☐ To ☐ From

Name: _____ Phone Number/Fax: _____

Documents or type of Information to be shared:

☐ Psychological Evaluation ☐ Treatment Plan ☐ Verbal Communication

☐ School Records ☐ Other Documents or type of information (Please specify):

I understand that New Mexico law requires the consent of the patient for the release of confidential information related to treatment and care while in treatment. With this understanding, I waive any right to confidentiality arising under New Mexico law and authorize release of medical and mental health record information. Redisclosure may not be accomplished without my further specific consent.
This authorization will expire (12) months from the date signed unless an earlier date is specified here: _____. Please be aware that this consent may be revoked at any time prior to the above date unless action on this release has already begun.

_____ _____
Signature of the Client or Legal Guardian Date

_____ _____
Signature of witness Date