Sara Lee, LCSW
595 East Colorado Blvd., Suite 331
Pasadena, CA 91101
(626) 485-6808

Consent to Release Information from Medical Records

Patient's Name:_____________________________________

I request and authorize Sara Lee, LCSW (20383) to disclose information from my health records which were obtained during my diagnosis and treatment to:

[Name]: ____

[Street address]: _____________________________________

[City, ST ZIP Code]: _________________________________

The disclosure of these records are required for the purpose of:

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This consent will become effective immediately. If it is not revoked earlier, it will remain in effect for THREE YEARS from the date of signature. I am fully aware that certain State and Federal Regulations protect the confidentiality of the information in these records. These regulations also require that I voluntarily sign this document before any release of records, and I may refuse to sign my signature, in which event the records cannot and will not be released by this office. This consent includes all records of medical, psychiatric, and/or substance abuse diagnoses, examinations, treatments, prognosis, counseling and/or therapy which may be subject to the confidentiality requirement of Section 5328 of the California Welfare and Institutions Code and/or 42 C.F.R., Part 2, Federal Register.

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Signature of Patient Date

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Signature of Parent/Legal Guardian Date