Sara Lee, LCSW
595 East Colorado Blvd., Suite 622
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:

_____
_____
_____

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.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date