Consent of Release
Confidential Information

Clearwater Counseling and Assessment Services
1 Bates Blvd, Ste 400
Orinda, CA 94563
(510) 596-8137

I hereby authorize _____at *Clearwater Counseling and Assessment Services* and:

_____

_____

_____

_____

to exchange information and records obtained in the evaluation and/or treatment of

_____.

I understand that I have a right to receive a copy of this authorization. The disclosure of information and records authorized herein is requested for the following purpose(s): ____ _____.

The specific types of information and the uses of the information to be disclosed shall be limited in the following ways: _____ _____.

This authorization shall remain valid until _____ or for one year, whichever comes first, and may be revoked in writing at any time. A fax or copy of this document shall be valid.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian (for minors) Date

Pursuant to the Confidentiality of Medical Information Act