Claremont Counseling and Support Center
Authorization to Release Clinical File

www.claremontcounseling.com
250 W. First Street Suite 230
Claremont, CA 91711
909-624-1997
909-624-4409 fax

I, (name if client) _____ hereby authorize (name of provider) _____ to release confidential information obtained during the course of my treatment to (name and function of the person(s) or entities to which information is to be released)

_____

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This authorization permit's the release of the following information:

____ Clinical File including:

____ Intake ____ Treatment Plan ____ Diagnosis

____ Prognosis ____ Progress to Date ____ Clinical Test Results

____ Dates of Treatment ____ Patient Records ____ Summary of Treatment

____ Other _____

I authorize the release of the information described above for the purpose of continuity of care.

I understand that I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

_____ _____
Signature of Client Date