Therapeutic Time, Inc.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

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By signing this document, I hereby authorize (check one):
- ☐ **Dr. Trisha Rich-Thurm, Clinical Psychologist PSY 24976**
- ☐ **Liliana Weichold, MA, Psychological Associate PA# PBS94027514**
- ☐ **Sarah Barajas, MA, Psychological Associate PA# PSB 94027905**

By signing this document, I, [name of patient] _____

hereby authorize my therapist to **disclose information and records obtained in the course of my diagnosis and or treatment to**:

NAME: _____

ADDRESS: _____

PHONE: _____Fax: _____ Email: _____

This disclosure of information and records authorized herein is required for the following purpose: (please circle and describe below if needed) **Billing Purposes** **Diagnosis** **Coordinate Care**

_____

_____

Such disclosure shall be limited to the following specific types of information: (please circle and describe below if needed) **All records** **Diagnosis** **Treatment Dates** **Treatment Goals & Progress**

_____

_____

***I understand that any cancellation of this authorization must be in writing.**

This authorization shall remain valid **until a year from this date.

**Date: _____

*Signature [of patient, parent, or guardian]: _____

Date of Birth or Social Security Number [of patient]: _____

Note that this sample form can be altered to allow a legal representative of a patient, or a beneficiary or personal representative of a deceased patient to authorize the release of confidential information. Reference: California Civil Code Section 56.11