



Therapeutic Time, Inc.

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Sarah Barajas, MA, Psychological Associate PSB 94027905

Liliana Chavez Weichold, MA, Psychological Associate PSB 94027514

Dr. Trisha Rich-Thurm, PsyD, Licensed as a Clinical Psychologist PSY 24976,

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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

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