

Specialty Behavioral Health
3262 Holiday Ct., Suite 208
La Jolla, CA 92037
858-752-3520 ph
858-452-6700 fx

Name _____
Date of Birth _____ Sex _____
Social Security # _____

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

I, _____, hereby authorize Specialty Behavioral Health and/or James Carter, Ph.D. to:

- release information to
- obtain information from
- exchange information with

Name(s): _____

Agency: _____

Address: _____

Telephone / FAX: _____

Please initial each category of specific information that you are allowing to be released. Write 'NO' in categories of information that you are not allowing to be released.

- _____ Verification of services received
- _____ Dates of treatment
- _____ Treatment summary
- _____ Letter(s) of support
- _____ Psychological and/or psycho-diagnostic assessment
- _____ Psychological testing results
- _____ Psychiatric and psychological counseling record
- _____ Medication record
- _____ Alcohol and substance use history
- _____ HIV status
- _____ Oral communication as needed

The information is being released for the following purpose(s):

- Coordination of treatment/care Submission for insurance coverage
- Family consultation and/or meeting Other _____

This consent will automatically expire one year after your last appointment with Dr. Carter.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released). This revocation must be delivered in writing to each of the treatment providers listed above.

Printed Name of Client / Patient

Printed Name of Witness

Signature of Client / Patient

Date

Signature of Witness

Date