Yvonne Venger, LCSW
Wellbeing Within Therapy San Diego

Authorization to Release Information

I____, give permission to **Yvonne Venger, LCSW** to release:

- Verbal ______
- Written _____
- Treatment Summary______
- My Entire Record______
- Letter to__________________________________Dated______________
- Other (specify)____

To: Recipient's Name____

Address____

Phone Number____

Recipient's Relationship to Client____

Regarding (Client)__________________________________D.O.B.____________

Purpose of Release____

This authorization for use of disclosure of medical information is being authorized by me giving Yvonne Venger, LCSW permission to disclose mental health/psychiatric records and information obtained in the course of the diagnosis and/or treatment of my child or me. I understand that the information disclosed pursuant to this Authorization might be re-disclosed by the recipient and may no longer be protected by the Federal Privacy Regulation {45 CFR Part 164}. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code.

Time frame of Release From____________To_______________

I may revoke consent at any time except to the extent that action has been taken in reliance upon it.

If it is not earlier revoked, this consent shall terminate without express revocation one year from date show below.

Date: __________________________

Signed: ____

If signed by other than client, please indicate relationship.

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