COGNITIVE THERAPY ORANGE COUNTY

151 KALMUS DRIVE, SUITE B/220 • COSTA MESA, CA 92626 • (949) 675-0545 • FAX (714) 437- 1687 • WWW.COGNITIVETHERAPYOC.COM

Authorization For Release of Information

I authorize:
Name (s): _____
Address: _____
Address: _____
Office telephone: _____
Office fax: _____

to release information and/or records regarding my treatment to:

_____ (←Printed name of clinician)
Cognitive Therapy Orange County (CTOC)
151 Kalmus Drive, Suite B/220
Costa Mesa, CA 92626 949 675 0545 Fax 949 437 1687

I understand I have the right to limit the type of information released. If I choose to limit the information released, I understand that it may be necessary CTCA to inform the requestor that portions of the record have been withheld.

Unless otherwise indicated below, my signature authorizes release of all records without exception.

_____
_____
_____

This consent is subject to written revocation by the undersigned at any time except to the extent action has been taken, and if not revoked earlier, this consent shall become invalid when rescinded by patient in writing.

I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

I understand I have a right to receive a copy of this Authorization, if requested.

A photocopy, digital copy or facsimile of this Authorization shall be as valid as the original.

_____ _____
Patient Printed Name Patient Phone

_____
Patient Date of Birth

_____ _____
Patient Signature Date

_____ _____
CTOC Clinician Signature *(rev: 11/2013)* Date