Cognitive Behavioral Therapy Services, Inc.
2111 S. El Camino Real Suite 302
Oceanside, CA 92054
Tel: 760.931.0521
FAX: 760.931.0581

Consent for Release of Information

I hereby authorize: Chris Tammariello, LCSW of Cognitive Behavioral Therapy Services, Inc.

☒ **To Release Information to:** ☒ **To Obtain Information from:**
(Check one box or both. By checking both, you are authorizing an exchange of information between the agencies/individuals listed.)

_____

Name of Agency/Individual **TEL**

_____

Address **FAX**

From the records of:

_____ _____
Name of Patient Date of Birth

Purpose or need of disclosure: *(check all that apply)*

☒ Consultation ☒ Mental Health and/or substance abuse assessment/treatment
☒ Coordination of Services ☐ Crisis Management
☒ Medical assessment\treatment ☒ Referral planning

Other_____

Types of information to be disclosed: *(check all that apply)*

☒ Medical ☐ Developmental ☐ Educational ☐ HIV
☒ Mental Health ☐ Drug and Alcohol ☐ Legal ☐ Other_____

Specific information to be disclosed: *(check all that apply)*

☒ Diagnoses ☒ Assessment ☐ Case Notes
☒ History ☒ Treatment Plans ☒ Treatment Summary
☒ Intake Summary ☒ Clinical Impressions ☒ Discharge Summary
☐ Other: _____

This consent will expire on: (unless revoked earlier orally or in written communication to the authorized named above)
___/___ /___

_____ _____
Patient Signature/Legal Guardian **Date**

_____ _____
Witness **Date**