Cognitive Behavioral Therapy Services
2111 S. El Camino Real Suite 302
Oceanside, CA 92054
Tel: 760.730.0521
FAX: 760.730.0581

Consent for Release of Information

I hereby authorize: Leanna Aubel,MFT 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**