Andrea S. Kahrs
LMFT # 118445
(424) 888-0368
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andreaskahrs.com

Release/Disclosure of Confidential Records or Information

Client _____
Last First Middle

D.O.B _____ Date _____

This will authorize Andrea S. Kahrs to release and receive general, medical psychological/psychiatric information including alcohol/drug abuse or addiction from my health records in accordance with [CA] Statues and [CA] Federal Administrative Rules and Regulations to/from: (enter individual's name you would like me to contact)

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Email Address _____

Information to be received is as follows:

[ ] Histories and Physicals
[ ] Psychological Testing Raw Data
[ ] Reports of Psychological Testing
[ ] Hospital Discharge Summary
[ ] Office Notes
[ ] Other: Verbal treatment review

Purpose of Release:

[ ] Continued Treatment
[ ] Psychological/Neuropsychological Evaluation
[ ] At the request of the patient
[ ] Other

Release Duration:

[ ] One Time
[ ] Continuous for 1 year

I understand that I have the right to refuse to sign this authorization and that the facility named above is released from all legal liability that may arise from the release of the information requested. Consent is subject to revocation at any time except to the extent that the action based on this consent has already been taken. This authorization for release will automatically expire without further action 1 year after the date on which it was signed.

_____	_____
Client signature	Date
_____	_____
Parent/Legal Guardian signature	Date
_____	_____
Signature of Witness to Above Signatures	Date

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