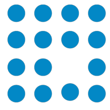
OCD • ANXIETY PROGRAM
OF SOUTHERN CALIFORNIA

Request/Authorization to Release Confidential Records and Information

A. Identifying information about me/the patient

Name: ______________________ Phone: ______________ Birth date: ____________

Address: ______________________________ Social Security #: ______________

Parent/guardian (if applicable): ______________________________

Address and phone of parent/guardian: ______________________________

B. I authorize release TO/FROM:

Person or facility: OCD & Anxiety Program of Southern California

Address: 2656 29th Street Suite 208 Santa Monica, CA 90405

Phone: 310-488-5850 FAX: ______________________

TO/FROM:

Person or facility: ______________________ Address: ______________________

Phone: ______________________ FAX: ______________________

For the purposes of: ______________________________

C. I hereby authorize the sources named above to release verbal and/or written information from the records listed below marked by an X in the boxes below. (The items not to be released have a line drawn through them.)

Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:

Date(s) of inpatient admission: ______________________________

Date(s) of outpatient treatment: ______________________________

Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.

Treatment plans, recovery plans, aftercare plans.

Social histories, assessments with diagnoses, prognoses recommendations, and all similar documents.

Academic or educational records.

Achievement and other testing results.

A letter containing dates of treatment(s) and a summary of progress.

Psychiatric evaluations, reports, or treatment notes and summaries.

Report of teachers' observations.

Admission and discharge summaries.

Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

Billing records.

I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire 30 days from the date I discharge from treatment.

Signatures:

X________________	X________________	X________________	
Signature of client	Printed name	Date	
________________	________________	________________	________
Signature of parent/guardian/representative	Printed name	Relationship	Date
________________	________________	________________	
Signature of professional	Printed name	Date	