(re) Define Health
3160 Camino del Rio S #304, San Diego, CA 92108
T 619-819-0283 x._____ **F** _____
www.potentiatherapy.com

Authorization to Release Confidential Information Pursuant to The Confidentiality of Medical Information Act

I hereby request and authorize _____
doctor, therapist, school agency, etc.

_____
street address city state zip

and
Potentia Family Therapy

__ **Rebecca Bass-Ching, LMFT** __ **Megan Holt, DrPH, MPH, RD**
__ **Molly La Croix, LMFT** __ **Kelly Schauermann, CPRYT, YT**
__ **Melissa McCormick, MFT Intern** __ **Roxanne Strauss, MFT Intern**
__ **Susan Workman, MFT Intern** __ **Kayla Walker, MFT Intern** __ **Brian Reiswig, MFT Intern**

to exchange all pertinent records and information concerning the psychological and/or medical history with each other regarding the below listed client. This release shall remain in effect for
__ six (6) months__ twelve (12) months
and may be revoked in writing by the undersigned at any time.

_____ _____
Name of Client Date of Birth

_____ _____

Name of Client _____ Date of Birth _____

Signature _____ Date Signed _____

Relationship to Client _____

I would like a copy of this release: __ Yes __ No

NOTICE TO RECEIVING FACILITY/THERAPIST:

- You may not disclose any of this information unless the person who consented to this disclosure specifically consents to such disclosure.
- I understand that there is a potential for re-disclosure of this information by the recipients and, if that occurs, the iinformation may not be protected by federal law.

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