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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

Chris Cessna, LMFT

Stephanie Godwin, MFT Intern

Megan Holt, DrPH, MPH, RD

Daniel Kim, LMFT

Molly La Croix, LMFT

Melissa McCormick, MFT Intern

Sally Peterson, LCSW

Kelly Schaueremann, CPRYT, YT

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 information may not be protected by federal law.



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