THE COASTAL WELLNESS CENTER
PROVIDING HOPE & HEALING ONE PERSON AT A TIME

I hereby authorize … CHRISTOPHER CANCLINI LMFT.
330 JAMES WAY SUITE 180
PISMO BEACH, CA 93449

Other … _____
_____
_____

TO RELEASE to (Person, Organization or Facility):_____

Address:_____

Information from records about_____ , born on_____

Whose social security number is_____. For the following purpose (s):

- ❑ Mental health evaluation, treatment, or care
- ❑ Rehabilitation program development or services
- ❑ Treatment Planning
- ❑ Other _____

These records concern the time between _____ and _____

The information to be disclosed is marked by an X in the boxes below.

Page numbers are indicated when appropriate.

- ❑ Intake and Discharge Summaries
- ❑ Medical History, Mental Health and Evaluation (s)
- ❑ Progress notes, and Treatment or Closing Summary
- ❑ Developmental and/or Social History
- ❑ Educational Records

Other:_____
_____

- ❑ HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ____ Do Not Release. Do Release

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically one year (1) from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed Name	Date
_____	_____	_____
Signature of Parent or Guardian	Printed name	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his/her consent.

_____	_____	_____
Signature of Witness/Therapist	Printed name	Date

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