CAV Family Therapy Inc.
Authorization to Release Psychological Records

Patient Name	Birthdate

I hereby authorize the following release:
CAV Family Therapy Inc, its agents, employees, or servants may disclose my psychiatric and/or psychological records and information obtained in the course of my diagnosis and treatment at this facility to:

Name	Agent/Facility/school/physician
StreetAddress	Phone ( )

Who may, in turn, release psychiatric and/or psychological records and information to CAV Family Therapy Inc.
Personal contact, including phone calls and face-to-face meetings, may be initiated by either party when deemed necessary, within the time-frame specified.

Purpose(s) of Release

Such disclosures shall be limited to the following specific information.

☐ DischargeSummary ☐ Psychiatrichistory &MedicalStatus ☐ LabReports

☐ Progressnotes &BriefReview ☐ Resultofpsychologic altests ☐ EducationAssessment &Reports

☐ Other: _____

This consent is subject to revocation by the undersigned at anytime, except to the extent that action has been taken in reliance there on and if not earlier revoked it shall terminate on_____.

Release or transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further transfer of information.

I understand that I have the right to receive a copy and this authorization if I so request. (A copy is valid as the original). I am fully

aware that certain state and federal statutes and regulations require that I voluntarily sign this document before
CAV Family Therapy Inc. can release any records, and that I may refuse to sign my signature, but in that event the records cannot and will not be released by the CAV Family Therapy Inc. I free both above named parties of any liabilities if ever I revoke my decision to release the data.

PatientSignature	Date	WitnessSignature	Date
Parent/Guardian/Responsible PartySignature	Date	Therapist/PhysicianSignature	Date