Michelle G. Ashley, M.D.
12304 Santa Monica Boulevard Suite 212
Los Angeles, CA 90025
Telephone/Fax: (310) 582-5223

**CONSENT TO RELEASE INFORMATION**

I, _____, Social Security # _____, Date of Birth _____, hereby authorize Michelle G. Ashley, M.D. to release and receive any and all information and related records regarding mental health, substance abuse, medical health, social history, and treatment including labs, medications, and diagnosis to and from the individuals or entities named below.

Name, Address, and Telephone of Individuals or Entities Information May be Released To and Received From:

---

_____

This information may be needed for clinical consultation, evaluation, or treatment planning. This consent shall become effective _____. I may revoke this authorization at any time by writing a letter to Michelle G. Ashley, M.D. Revocation would not affect disclosures that have already taken place prior to revocation. If not previously revoked, this consent will terminate when treatment terminates.

I release Michelle G. Ashley, M. D. from any liability arising from the release of this information and/or records

Patient's Signature:_____ Date:_____

Guardian or Personal Representative's Signature:_____ Date:_____