



Office of Harmony Satre, PsyD

Licensed Psychologist, PSY22871

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Consent to Release or Obtain Confidential Information

Client _____ Date of Birth _____

I hereby authorize and request the exchange of information and release of records regarding psychiatric and/or medical treatment between _____ (Psychology Assistant) / Dr. Harmony Satre, PsyD and:

Name/Agency _____ Address _____

Phone Number _____ Fax _____

I understand I have the right to receive a copy of this authorization. I understand that this consent to release information will stand for *one year after the date of request*, until termination of therapy or until rescinded in writing.

For the purpose of: Evaluation Treatment Planning/Course

Other: _____

And shall be limited to the following specific types of information:

- | | | |
|--|---|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Social History | <input type="checkbox"/> Treatment or Client Plan |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> School Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lab Tests | <input type="checkbox"/> HIV or AIDS Information | _____ |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Psychological/Vocational Testing | _____ |

Accumulated during the period beginning (month/day/year): _____ through: _____

Specific uses for information being released: _____

State law and DMH Regulation prohibit making any further disclosure of this information without the informed consent from the person to whom this information pertains. Alcohol and Drug Abuse patient records are protected specifically under Federal Regulation 42 CFR Part 2. HIV and AIDS information disclosure is governed by California Civil Code 56 and health and Safety Codes 199.21, Section (G). SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND EVIDENCE CODE SECTION 1014.

Client, Parent /Legal Guardian Signature

Date

Clinician Signature

Date