Yoffe Therapy
Child & Family Therapy

2001 S. Barrington Ave, Suite 214, Los Angeles, CA 90025

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____Date of Birth: ___/___/___

This will authorize:

_____

_____

_____

To Release information to/from: _____

2001 S. Barrington Ave., Ste 214
Los Angeles, CA 90025
Contact # (310-351-8113)

The following information concerning my child's treatment:

___Admission Summary

___Discharge Summary

___Medical Reports

___Phone Consultation

___Psychological Evaluation

___Psychiatric Evaluation

___Psycho Education Test Results

___Other _____

The information hereby released will be used for: **Case Consultation.**
I understand that these records are protected by the California welfare and institution code section 5328 and that additional consent must be obtained for any other transfer or disclosure of information. The authorization shall become effective ___/___/___ and may be revoked by the undersigned party at any time. If not earlier revoked, this consent shall terminate on ___/___/___. Termination date should not exceed 90 days from effective date unless treatment plan justifies ongoing communication with the above named. Under no circumstances should termination date exceed one year.

I understand I have a right to receive a copy of this authorization if I so request.

_____ _____
Date Signature of Patient (12 and over)

_____ _____
Signature of Witness Signature of Parent/Guardian