BALANCE

Center for Mental Health and Wellness

CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

We, _____, (DOB) _____ and

_____, (DOB) _____

hereby authorize Kimberly Panganiban, MFT #52717 to release to and/or receive from:

Person/agency/facility _____

Address _____

City, State, Zip _____ Phone _____

the specific information indicated below regarding the services provided to me for the period

from _____ to _____ for the following purpose(s):

Coordination of care Treatment planning Evaluation Litigation Other: _____

This disclosure is specifically intended to include any references to diagnosis, testing, mental health services and drug and/or alcohol services. This authorization is limited to the following information:

____ All Records
____ Diagnosis
____ Developmental History
____ Medical History
____ Progress Notes
____ Treatment Plan
____ Treatment Summary
____ Other: _____

____ Psychological Evaluation
____ Discharge Summary

Expiration Date: _____

We understand the above consent is subject to revocation by us at any time, except to the extent that action has been taken in reliance on this consent prior to revocation.

Client Signature:_____ Date: _____

Client Signature:_____ Date: _____