Sanctuary by the Sea Counseling Services (SSCS)

Authorization to Release Information

Authorization to Release Confidential Information Pursuant to The Confidentiality of Medical Information Act

I hereby request and authorize _____, doctor, therapist, school agency, etc.
_____ street address,
_____ city,
_____ state and zip code,

and Sanctuary By The Sea Counseling Services (SSCS) and/or Crystal Duncan, LCSW CA61763 to exchange all pertinent records and information concerning the psychological and/or medical history with each other regarding the below listed client. This release shall remain in effect for six (6) months and can be extended to twelve (12) months and may be revoked at any time in writing by the undersigned.

Name of Client _____
_____ street address,
_____ city,
_____ state and zip code,
Date of Birth _____

Signature _____
Date Signed _____
Relationship to Client _____

I would like a copy of this release: __ Yes __ No

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not disclose any of this information unless the person who consented to this disclosure specifically consents to such disclosure.

I understand that there is a potential for re-disclosure of this information by the recipients and, if that occurs, the information may not be protected by federal law.