AUTHORIZATION FOR RELEASE OF INFORMATION

PRINTED PATIENT'S NAME: ______________________________________
DATE OF BIRTH: __________________SOC. SEC. #____________________
DATES OF TREATMENT: ____

I hereby authorize Dr. Nicki Pike, PsyD, LCSW, located at 2900 Bristol Street, Bldg. G ~ Suite 103, Costa Mesa, CA 92626 to release/ disclose/discuss the above named individual's health and or mental health information with the professional identified below. Dr. Pike can be contacted by phone at (714) 838-5253 or FAX (949) 313-1701

The purpose of this release of information is to_________________________________.

The information to be disclosed is as listed, please be specific

______Assessment/History

______Discharge Summary

______Entire Record – Date(s) of Service:____________________________________

______Photographs, videotapes, digital, or other images

______Other, please specify needed information and date(s) of service if known______

____

I understand that the information to be discussed pertains to my behavioral or mental health treatment including but not limited to treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise. ______________________________________

____

The information is to be released to:

Name: ____

Address: ____

Phone/FAX:____

Patient or Authorized Signature___________________________________

Relationship to Patient________________________

Date ____________________ This authorization will be in effect for a period of one year unless patient wishes to terminate authorization before that time.