Dr. Jose Sandoval
CHANGE YOUR LIFE

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client's Name: Date of Birth:
Social Security #:

This will authorize Dr. Jose A. Sandoval to release /receive general medical, as well as psychiatric/psychological information from my record,

☐ TO / FROM: (Identify Individual as well as agency, departmental affiliation, address, etc.):

The Specific Information Requested is

☐	Treatment Summary	☐	History
☐	Physical	☐	Neuropsychological Testing
☐	Psychological Testing	☐	Psychiatric Evaluation/Consultation
☐	Acknowledgement of Treatment	☐	Verbal Report
☐	Other (specify):		

For the purpose of: ☐ Evaluation & Continuing Treatment

☐ Other (specify):

I understand that I have the right to refuse to sign this authorization, and that the member named above as the releasing agent is released from all legal liability that may arise from the release of the information requested.

I further understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected (under Title 42 of the Federal Code) and that re-disclosure of this information by the receiving agency is prohibited.

This authorization is for a ☐ single, or a □ continuing disclosure, which is valid for ninety (90) days after the date of my signature as it appears below.

Signature of Client: _____ Date: _____

Signature of Witness: _____ Date: _____