Consent to Exchange Confidential Information

Date: _____

To: (Health Professional/Facility)_____

Phone: _____

Fax: _____

Client Name: _____

Please release to Authenticity Associates the following medical records or other materials for the purpose of collaboration and continuity of care**:**

- ___ **Psychology/Psychiatric reports**
- ___ **Other medical information**_____

Dates of Treatment: _____

This authorization is valid for 90 days, unless otherwise specified.

Patient Signatures:_____**Date**:_____
*Below age 18: Patient and parent/legal guardian must sign and date.

Other Signatures:_____**Date**:_____
(State relationship to patient)

Please submit these materials to Authenticity Associates

Phone (619) 819-6841
contact@authenticityasssociates.com