# PSYCHOLOGICAL SERVICES FOR FAMILIES
# 410 North A Street
# Oxnard, CA 93030
# 805-487-2244 Fax 805-487-2255

## AUTHORIZATION TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

I/We_____D.O.B._____,do hereby authorize the above-named Provider to disclose records and mental health treatment information obtained during the course of psychotherapy treatment for the above named client to:

Primary Care Physician _____
Address _____
Phone # _____ Fax # _____

This Authorization to disclose records and information is required for the following purpose(s):
___Disclose to exchange Treatment plan, Medication list, Allergies, Anxiety and Depression Screening and ADD/ADHD Screening_____

I accept _____ I decline _____

Signature of Client or, if client is a child, above listed Parent/Guardian

_____ _____
Signature Date