The Sacramento Institute
for Psychotherapy

# *Consent to Release / Obtain Information*

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**DIRECTIONS:**
Please sign the agreement below giving us permission to release and/or obtain information on your behalf from the individuals and agencies listed below.

**CONTACT INFORMATION:**
I give consent for The Sacramento Institute for Psychotherapy, its employees, representatives, and contractors to release and/or obtain any information deemed necessary to/from the following persons/agencies:

1) Name of Person /Agency: _____
Address: _____
Phone: _____ Fax: _____

2) Name of Person /Agency: _____
Address: _____
Phone: _____ Fax: _____

3) Name of Person /Agency: _____
Address: _____
Phone: _____ Fax: _____

**INFORMATION TO BE OBTAINED AND/OR RELEASED:**
I consent to disclosure of (please check all that apply or mark "All"):

- ❑ All Records Listed Below
- ❑ Substance Use Treatment Records
- ❑ Financial/Scheduling/Billing Records
- ❑ Medical/Mental Health information
- ❑ HIV/AIDS related information
- ❑ Other: _____

**TIME FRAME:**
This authorization is valid for 5 years or until revoked by me (the patient), whichever comes first.

_____ _____
*Patient Name* *Guardian Name (if patient is a minor)*

_____ _____
*Patient Signature* *Guardian Signature (if patient is a minor)*

_____ _____
*Date* *Date*