# Real Life Therapy

## Consent to Obtain and/or Release Confidential Information

### Confidential Patient Information

Please Note: CLIENT CONFIDENTIALITY IS PROTECTED UNDER CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND EVIDENCE CODE SECTION 1014. STATE LAW AND D.M.H. REGULATION PROHIBIT MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE INFORMED CONSENT FROM THE PERSON TO WHOM THIS INFORMATION PERTAINS. PLEASE SEE CALIFORNMIA CIVIL CODE SECTION 56.10, WHICH PERTAINS TO THE DISCLOSURE OF MEDICAL INFORMATION BY HEALTH CARE PROVIDERS, AND CALIFORNIA CIVIL CODE, SECTION 56.11, WHICH DESCRIBES THE REQUIREMENTS APPLICABLE TO AUTHORIZATIONS FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION. YOUR AUTHORIZATION ALLOWS **REAL LIFE THERAPY AND ITS PROVIDERS** TO RELEASE YOUR PROTECTED HEALTH INFORMATION TO A PERSON OR ORGANIZATION THAT YOU CHOOSE. YOU CAN REVOKE THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A REQUEST IN WRITING TO **REAL LIFE THERAPY**. REVOKING THIS AUTHORIZATION WILL NOT AFFECT ANY ACTION TAKEN PRIOR TO RECEIPT OF YOUR WRITTEN REQUEST.

CLIENT NAME: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____-____-_____

I HEREBY AUTHORIZE: (Select one)

❑ The Exchange of Information

❑ Release of Records accumulated during the time period beginning (Month/Date/Year) ___/____/____ through (month/Date/Year) ____/____/____

Other: _____

❑ BETWEEN ❑ FROM ❑ TO (Select one)

Real Life Therapy Phone: _____

Provider: _____ Provider email: _____

3750 Auburn Blvd, Suite C Fax: (866) 462-4494

Sacramento, CA 95821

Secured email: Direct@RealLifeTherapySacramentoCA.Compulink.com

www.RealLifeTherapy.com

❑ AND ❑ TO ❑ FROM (Select one)

Name of Person or Professional: _____

Address _____ Telephone: ____-_____-_____ Fax: _____-_____-_____

City_____ State _____ ZIP _____

FOR THE PURPOSE OF:

❑ Evaluation ❑ Treatment planning ❑ Coordination of care ❑ Other: _____

CONFIDENTIAL INFORMATION TO BE OBTAINED AND/OR RELEASED INCLUDES:

_____Entire Record _____Mental Health Info. _____Include HIV or AIDS info. _____Medications

_____Medical Information/Labs _____Psychiatric/Psychological Assessment _____School Information

____Include Alcohol/Drug Info. _____Treatment Plan/Response _____Diagnosis _____Discharge Summary

Other:_____

DURATION: This consent can be revoked by the undersigned grantor at any time. If not revoked earlier, it shall terminate in one year on ___/____/____.

**By signing below, I authorize the use of my protected health information.**

Client Signature : _____Date : ____/____/_____

Client Signature : _____Date : ____/____/_____

Parental/Guardian Signature: _____Date: ____/____/_____

Parental/Guardian Signature: _____Date: ____/____/_____

Professional Signature: _____Date: ____/____/_____

Date Release Mailed/Faxed: ____/____/_____ Date Material Mailed/Faxed: ____/____/_____