

Center For Cognitive Therapy

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AUTHORIZATION TO RELEASE INFORMATION

I _____ authorize the Center for Cognitive Therapy to release
(print client's full name)
psychological information which may have been acquired in a professional capacity concerning

my evaluation and/or treatment to: (name) _____
(address) _____
(address) _____
Phone: () _____ Fax: () _____

The information being released is: _____
(specify nature/extent of released information)

for the purpose of: _____
(specify reason for information to be released)

I understand that I may revoke this consent to release information by oral or written communication. I also understand that any release which has been made prior to my revocation and which was based upon this authorization shall not constitute a breach of my right to confidentiality.

Unless I revoke this authorization prior to such time, it shall remain valid for 180 days ending on _____

(signature of client) (DOB) (authorization date)

(parent, guardian, or legal representative) (authorization date)

Address: _____

(signature of staff witnessing consent) (date)