David A. Donovan, PhD

CLINICAL PSYCHOLOGY

CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

I, _____, _____ hereby authorize
[Name of patient] *[Date of birth]*

David A. Donovan, PhD, to disclose to, or exchange verbal or written information with:

_____
[Name, title of person, phone number and address of person, dept. or agency receiving information]

For the purpose of diagnosis, treatment planning, continuity of care, and the provision of quality of care. I understand that all relevant information may be exchanged with the full knowledge that such contact discloses that I am receiving/have received mental health services. I further understand that these records may contain information regarding psychological or psychiatric conditions, psychological assessment, substance use, sickle cell anemia, acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV), among others.

I may limit the scope of information released by indicating any limitations in the space below [please use additional space if needed]. If no limitations placed, please write "NONE" in the space below.

_____

_____

This disclosure will expire on _____ , or one year from the present date, whichever is less.

This authorization for release or disclosure of medical information is provided under the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et. seq., of the California Civil Code.

Signed _____ Date _____
Client/Patient

Signed _____ Date _____
Parent, Guardian, or Conservator

_____ Date _____
Relation to Client/Patient

Signed _____ Date _____
Witness Signature

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