Westlake Village Family Services
3625 E. Thousand Oaks Blvd. Suite 225
Westlake Village, CA. 91362

Authorization to Release Confidential Information

I, ____

hereby authorize Westlake Village Family Services

to release confidential information obtained during the course of my treatment to:

This Authorization permits the release of the following information:

__X__ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment

____Other

____

____

I authorize the release of the information described above for the following purpose(s): Case Management and Continuity of Care

The recipient may use the information described above solely for the following purpose(s): Case Management and Continuity of Care

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.
This Authorization shall remain valid until: ("Expiration Date") _________

By: ________________________Date:_____________________________
(Patient or Patient's Representative*)
*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

____

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Westlake Village Family Services
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Westlake Village, CA. 91362

Authorization to Exchange Confidential Information

I, ____

hereby authorize Westlake Village Family Services

to exchange confidential information obtained during the course of my treatment to:

This Authorization permits the release of the following information:

__X__ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment

____Other

____
____

I authorize the release of the information described above for the following purpose(s): Case Management and Continuity of Care

The recipient may use the information described above solely for the following purpose(s): Case Management and Continuity of Care

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.
This Authorization shall remain valid until: ("Expiration Date") _________

By: ________________________Date:______________________________
(Patient or Patient's Representative*)
*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

____

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