LOS GATOS THERAPY CENTER
CHILD, ADOLESCENT AND ADULT MENTAL HEALTH SERVICES

Consent to Release Mental Health Patient Records

I, __________________________, (or parent of___________________________) **hereby authorize the following person or organization:**

Name of Person or Organization ____

Address of Person or Organization ____

Phone ____

Fax ____

To disclose records obtained during treatment for:

□ Mental Health Purposes
□ Alcohol Abuse Purposes
□ Drug Abuse Purposes
□ Other (please specify) ___________________________________

Released records/information are to be sent to:

☐ **LOS GATOS THERAPY CENTER**
2542 S. BASCOM AVE, STE 110
CAMPBELL, CA 95008

☐ _______________________________
____
____
____

Please release the following information selected from below:

1. □All Medical Records or
□ Consultation and Progress Notes
□Doctor's Orders
□Laboratory Reports
□ Psychological Testing
□ Other (please specify) _______________________________

2. For the following time frame (mo/year): from ________________________ to ____________________

This consent is subject to revocation by the undersigned except to the extent that action has been taken in reliance hereon, and if not revoked, it shall automatically expire in twelve months from the date it was authorized.

Patient Name: ___________________________________ Date of Birth: ________________

Patient (or parent / guardian)
Signature: ____ Date:_______________