WAVE PROFESSIONAL CLINICAL COUNSELORS INC,
WAVE THERAPY
MARK BREWER, LMFT
1207 CARLSBAD VILLAGE DRIVE, SUITE #0
CARLSBAD, CA 92008
PHONE: (760) 500-3325 MFT #46057

Request for Release of Confidential Records and Information

I hereby authorize:
Person and/or facility: _____MARK C. BREWER, MA, LPCC, LMFT_____

Address: _____1207 Carlsbad Village Drive, Suite O, Carlsbad, CA 9208_____

Phone: _____760-500-3325_____

TO /FROM

I hereby authorize:
Person and/or facility: _____

Address: _____

Phone: _____

to release information from the records of _____, born on, _____

and whose Social Security number is_____, for the following purpose(s):

☐Further mental health evaluation, treatment, or care/continuity of care
☐Treatment planning
☐Other: _____

☐Please forward the above records to the address in the letterhead at the top of this form.
☐Please share the above information with Mark Brewer, LMFT or WAVE Therapy via phone/fax/e-mail for consultation.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after1 year from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/ guardian/representative	Printed name	Relationship	Date

_____	_____	_____
Signature of Therapist/Witness	Printed Name	Date