WAVE Professional Clinical Counselors Inc.

WAVE THERAPY
3150 Pio Pico Dr. Suite 105
CARLSBAD, CA 92008

(760) 500-3325

Request for Release of Confidential Records and Information

I hereby authorize WAVE Therapy and all its associates, located at 3150 Pio Pico Dr. Suite 105, Carlsbad, CA 92008, to contact and receive/release information/records:

To or From (the place you want records sent to or retrieved from)

Person and/or Facility:____

Address:____

Phone Number:________________________________Fax Number:________________________

I authorize the release of information from the records of (your information)

Full Name:____________________________________ Date of Birth:____________________

Social Security Number:____

The purpose of this release will be for:

- ☐ Further mental health evaluation, treatment, or care/continuity of care
- ☐ Treatment Planning
- ☐ Other____
- ☐ All of the above

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 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 after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above.

____ ____________________
Signature of client (or person acting for client) Date

____ ____________________
Printed Name Date of Birth