SUSAN MARTINEZ LEE, LCSW
Fax (805) 658-8503
(805) 654-1422

CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby give consent for Susan Martinez Lee, LCSW to [ ] obtain from the below named person or agency and/or [ ] release to the below named person or agency

Individual: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

confidential information as specified:

[ ] Admission/Psychiatric Assessment
[ ] Psychological Evaluation/MSE
[ ] Psychological/Vocational Tests
[ ] Psychological History
[ ] Service Plan/Treatment Plan
[ ] Health/Hospitalization History
[ ] Physician's Orders
[ ] Premarital Preparation Issues
[ ] Social History
[ ] Diagnosis
[ ] Educational Tests
[ ] Entire Record
[ ] Medication
[ ] Discharge Summary
[ ] Consultation Reports
[ ] Other _____

A copy or fax of this release is as valid as the original.

I understand that I may revoke this consent at any time. If not revoked earlier, it will automatically terminate one year from the date signed.

_____
Client or Guardian Signature Date

_____
Client or Guardian Signature Date