CARE-LA

10323 Santa Monica Blvd., Suites 102 & 103
Los Angeles, CA 90025
(424) 421-2273

RELEASE OF INFORMATION

By signing this document I, _____ , hereby authorize CARE-LA
(print full name)
permission to release or exchange information/records pertaining to me or my child and treatment with:

_____
Name of Person or Organization

_____
Street Address

_____
City State Zip

_____ _____
Phone Email

I understand that this authorization is valid for one (1) year from the date of signature below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

_____ _____
Signature of Patient or Parent/Guardian (if patient is a minor) Date

_____ _____
Provider Signature Date