

## Authorization for Release of Protected Health Information

I,	, whose Date of Birth is,
	authorize Alicia Outcalt, LCSW to disclose to and/or obtain from:
	the following information:
<u>Please in</u>	nitial any item(s) to be disclosed
	Any health, mental health and substance use information including treatment
	Mental Health information
	Participation in Treatment
	Other:
<u>Purpose:</u>	_
The purpos	se of this disclosure of information is to improve assessment and treatment planning, share
informatio	n relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please
specify:	
<u>Revocati</u>	
I have a rig	ght to revoke this authorization, in writing, at any time by sending written notification to Alicia
Outcalt a	at 3990 Old Town Avenue C203, San Diego, Ca 92110.
Expiration	on: Unless sooner revoked,
Please in	nitial oneThis consent expires at termination of this treatment
	ORThis consent expires on:
I understar	nd that Alicia Outcalt, LCSW will not condition my treatment on whether I give authorization for the
requested (	disclosure.
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Date

Signature of Patient

Signature of Parent, Guardian or Personal Representative

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).