Beth Elder, L.C.S.W.
18600 Main Street, #295
Huntington Beach, CA 92648
(949) 743-1775
Fax (714) 847-5860

I, _____, __/__/__, hereby authorize
(Name of Patient) (DOB)
Beth Elder, L.C.S.W. to provide information and records to:
(Name of Provider)

_____
(Name of Provider and/or Facility and/or Agency)

_____
(Address)

_____
(Phone Number)

Such disclosure shall be limited to the following specific information (Check those that apply).

__ Intake Evaluation
__ Initial Assessment Report
__ Medication/Psychiatric Evaluation
__ Continued Treatment Report
__ Medical History
__ Other (specify) _____

I understand that I may revoke this consent at any time, except to the extent that it has already been acted upon prior to my revocation. This consent shall become null and void one year after the date of the signature. I understand that if I would like to revoke this consent, I must put my request in writing and submit it to my provider.

Release or transfers of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information.

I understand that I have the right to receive a copy of this authorization if I so request.

_____ _____
(Signature of Patient/Guardian) (Date)