AshleyWilliams Counseling, Inc.
10900 E. 183rd St. Suite 105, Cerritos, CA. 90703
Main: (855) 530-1615 / Fax: (562) 275-8311
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Request/Authorization to Release Confidential Records and Information

I hereby authorize:
(Person or facility):______________________________

Address/City/State: ______________________________

Phone ____________ Fax: ____________ Email: ____________

To release information from records regarding, ____________ Date of Birth ____________

To: AshleyWilliams Counseling, Inc. at the address listed above, or in person (where applicable).

For the purpose of:

- ❑ Further mental health evaluation, treatment, or care
- ❑ Rehabilitation program development or services
- ❑ Treatment planning, consultation
- ❑ Research
- ❑ Other Consultation w/ relative professionals

In the boxes below, the information to be disclosed is marked by an X.

- ❑ Intake and discharge summaries
- ❑ Medical and/or psychiatric history and evaluation(s)
- ❑ Mental health evaluations
- ❑ Developmental and/or social history
- ❑ Educational records
- ❑ Progress notes, and treatment or closing summary
- ❑ Other: ______________________________

Select only one (if applicable):

- ❑ Please forward the records to the address in the letterhead at the top of this form.
- ❑ Please forward the records to the address written above.
- ❑ Other: Where agreed by parties involved.

Additional Information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely 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 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of client (or person acting for client)	Printed Name	Relationship	Date
Co-Signature of client (or person acting for client)	Printed Name	Relationship	Date

Signature of Psychologist ____________ Date ____________