Beach Psychotherapy
1767 Grand Ave. Suite 4
San Diego, CA 92109
(877) 293-8123

CONSENT FOR RELEASE OF PROFESSIONAL INFORMATION

Patient's Name:_____Date of birth_____

I hereby authorize _____ of Beach Psychotherapy to secure and release psychological, medical, social, educational and other clinical information regarding the patient named above. This authorization for an exchange of information applies only to the following individual or institution:

Name/ Institution:_____

Address:_____

Signature:_____Date_____

Name of Signer (Please print)_____

Relationship to patient:_____