LSC
LIVING SUCCESS CENTER
A Pathway to Mental Health & Wellness

Authorization to Release or Exchange Confidential Information

I, _____
(Client's Name)

Hereby authorize: Living Success Center, 445 E. 17th Street, Suite E, Costa Mesa, CA 92627

____ Release Information To: ____ Obtain Information From: ____ Exchange Information With:

Name: _____

Address: _____

Telephone: _____ Email: _____

SPECIFIC INFORMATON TO BE RELEASED: (Check each category that applies)

_____ **Dates of Treatments**
_____ **Diagnosis**
_____ **Clinical Test Results**
_____ **Any and All Information Necessary**
_____ **Treatment Plan**
_____ **Prognosis**
_____ **Progress to Date**
_____ **Other (specify)** : _____

For The Following Purpose(s):

____ Coordination of Treatment/Care
____ Administrative
____ Other _____

NOTICE: Living Success Center and other health care providers and organizations such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at anytime (except to the extent that the information has already been released.) This revocation must be delivered in writing to each of the treatment providers listed above.

This Consent shall remain valid until: _____("Expiration Date")

_____ _____
(Client's Signature or Legal Representative) (Date)

_____
(Printed Name)