

Authorization for Release of Information

To: _____

Address: _____

Phone: _____

I authorize: ___Rebecca Bass, MFT,
 ___Megan Holt, RD

Potentia Family Therapy, Inc.
2525 Camino del Rio S #315
San Diego, CA 92106
Phone: 619.280 3430 ext 129
Fax: 619.280 5420



To release/receive medical, psychological, and/or educational information concerning:

Name: _____

Address: _____

I understand that I have the right to revoke this authorization, in writing, at any time by notifying my therapist. I understand that a revocation is not valid to the extent that my therapist has acted in reliance on such authorization. It is your right to obtain a copy of this authorization.

This authorization is valid for one year or until date below.

A copy of this release shall have the same force and effect as the original.

Client Signature

Date

Parent/Guardian Signature

Date

NOTICE TO RECEIVING FACILITY/THERAPIST:

- You may not disclose any of this information unless the person who consented to this disclosure specifically consents to such disclosure.
- I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.