Phone: (949) 378-1047
Fax: (949) 215-2486

Consent To Release Records or Information

I,_____, hereby authorize the following individual (s) or Organization to exchange records or information with Marissa Kent, MS, RDN, CDE or any representative thereof, which may be acquired in a professional capacity concerning myself and deemed necessary for the purpose of assessment and treatment.

☐ I authorize the specific physician, psychologist, or counselor to release any medical or psychological records or information.

_____

(Physician or Therapist) (Phone #)

This contract is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on the date participation in counseling terminates.

_____

(Participant) (Date)

_____

(Witness) (Date)