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**Danville, CA 94526 800-313-9733**

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Robert Field, Ph.D. Ca. Licensed Psychologist PSY 5705

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | |
| Previous Name: | | | | | | |  | | | | Social Security #: | | | |  | | | | |
| I request and authorize | | | | | | | | | |  | | | | | | | | | to |
| release healthcare information of the patient named above to: | | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | | Robert Field, Ph.D./Quest Therapeutic Camps, Inc. | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | |
|  | | City: | | |  | | | | | | | State: |  | | | Zip Code: | |  | |
| This request and authorization applies to: | | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the participation in the Quest Therapeutic program | | | | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | | |
| 🞎 Other: | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of any records regarding my child’s mental health treatment to the person(s) listed above. | | | | | | | | | | | | | | | |
| Parent /Guardian Signature: | | | | | | | |  | | | | | Date Signed: | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | |
| THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED. | | | | | | | | | | | | | | | | | | | |