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**907 San Ramon Valley Suite 202**

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

**925-743-2900 FAX:925-820-9761**

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. |