Steven Steinberg, MBA, MCLC

(818) 257-2549

Calabasas:
23501 Park Sorrento Drive, Suite 101
Calabasas, CA 91302

Santa Clarita:
24359 Walnut Street, Unit A
Santa Clarita, CA. 91321

Client Release

I hereby authorize **(name and address of physician, health plan, school facility and staff or other holder of records)**_____to release the information which is contained in any psychiatric, medical, alcohol and/or drug abuse records which he/she/it may have regarding **(name of patient/client)**_____**(date of birth)**_____ interviewing and examining **(name of patient/client and address)**_____ _____including, but not limited to, any outpatient with a psychotherapist, under the conditions listed below:

Information which may be released is limited to all medical records or other information obtained by (holder of records) through interviews with **(name of patient/client)** _____ *or inquiries concerning((name of patient/client) will include all psychiatric, medical, school, alcohol and/or drug abuse records which are in the possession or control of (holder of records)* _____

Send records to: _____

Or speak with: _____

_____

_____

_____ _____

Patient's/Client's Signature **Date**

If the patient/client is a minor and could not lawfully consent to the services involved, or if the patient/client has been juducially determined to be incompetent:

_____ _____

Signature of legal representative of patient/client, such as a conservator of the person, an individual Granted a durable power of attorney, or a custodial Parent of a minor patient where the services involved could not be lawfully be consented to by the minor patient/client.

Date