Aspiring Families
Positive Tools for Thriving Families

HIPAA Authorization to Release Information

Federal law requires your specific authorization for release to appropriate parties any information about your or your child's treatment for certain conditions. Please check and sign all pertinent statements below giving your permission to communicate with the following individual, agency, school or organization on your or your child's behalf.

Client Name: _____

Date of Birth: _____

I hereby authorize: Aspiring Families
12625 High Bluff Drive, Suite 104
San Diego, CA 92130

To: Disclose to ☐ Obtain from ☐ Fax ☐ E-mail

The following individual, agency, school, or organization:
Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

The following information (please check):

☐ History & background ☐ Psychological evaluation/testing ☐ Summary report

☐ Psychiatric evaluation ☐ Service/treatment plan ☐ Consultation report

☐ Psychosocial evaluation ☐ Laboratory work and Test results ☐ Other (specify)

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The information is required for (please check):

☐ Diagnostic assessment ☐ Planning services ☐ Coordination/collaboration of client's care

☐ Planning treatment Other (specify) _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization become effective _____ and will expire one year from the date of signing, if not earlier revoked. I have been informed what information will be exchanged, its purpose, and who will receive the information. I am aware that such contact discloses the fact that mental health services have been/are being provided.

_____ _____
Signature of client Date
(Parent or Legal Guardian if under 18)

_____ _____
Printed name of client Parent or Legal Guardian if under 18

Relationship to the client: ☐ Self ☐ Guardian