Beach Psychology

**Dr. Kelly Warren (PSY27851)**

**2447 Pacific Coast Highway, suite 213**

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**310-947-9279**

**Authorization to Release Confidential Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize

Beach Psychology to release confidential Information obtained during the course of

treatment to Beach Psychology.

This authorization permits the release of the following information:

\_\_\_\_\_diagnosis \_\_\_\_\_treatment plan \_\_\_\_\_progress to date

\_\_\_\_\_prognosis \_\_\_\_\_test results \_\_\_\_\_documented history

\_\_\_\_\_other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of the information described above for the purpose of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have a right to receive a copy of this authorization and that

I may revoke or modify this authorization at any time and in writing. This shall

remain valid until \_\_\_\_\_\_\_ (expiration date)

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Please E-mail completed form to: [kellywarren100@gmail.com](mailto:kellywarren100@gmail.com)