Julia C. Kitts, LCSW
12625 High Bluff Dr. #111
San Diego, CA 92130

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF CONFIDENTIAL INFORMATION

CONFIDENTIAL INFORMATION REQUESTED TO/FROM:

Name of Health Care Provider	Name of Medical Office or Hospital
Street address	City, State & Zip Code
Phone Number	Fax Number

CONFIDENTIAL INFORMATION REQUESTED TO/FROM:

Julia C. Kitts, LCSW

12625 High Bluff Dr. #111 San Diego, CA 92130

Phone: (858) 243-0961 Fax: (858) 780-9250

I hereby authorize ***Julia C. Kitts, LCSW*** to release and/or disclose information as indicated below to the health care provider, entity, or person I have indicated above.

Release and/or disclose records and information regarding:

_____ _____
Name of Client **Date of Birth**

Duration: *This authorization will become effective immediately and shall remain in effect until _____ or for one year from the date of signature.*

***Revocation*:** *This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party.*

Circle and initial which type of information is to be released and/or disclosed:

Mental Health _____ Alcohol and Drug _____ Other (specify) _____
Initial Initial Initial

I request that the confidential information released and/or disclosed pursuant to this authorization be used for the following purposes only:_____.

I have a right to receive a copy of this authorization.

_____ _____ _____
Signature of Client or Client's Representative Date Indicate Relationship (if signed by other)