CHICO CENTER FOR
COGNITIVE
BEHAVIOR
THERAPY

JOEL MINDEN, PhD
CA LICENSE: PSY27859

Authorization to Release Confidential Information

I, _____ authorize Joel Minden, PhD, to release, request, and exchange
Name of client, parent or legal guardian
information and records obtained in the course of my diagnosis and treatment for the following purposes:

- Increase understanding of my previous history, diagnosis, and treatment
- Coordinate care on an ongoing basis with other providers who are also treating me
- Discuss my care with friends or family who may be important sources of support

Information can be released to, requested from, or exchanged with the following individual or organization:

Name of individual/organization	*Address*	*Phone number/fax*
_____	_____	_____

I authorize

☐ An exchange of information between Joel Minden and the individual or organization listed above
☐ A release of information from Joel Minden to the individual or organization listed above
☐ A release of information to Joel Minden from the individual or organization listed above

This release shall be limited to the following information (check all that apply):

☐ Billing and attendance in therapy
☐ Diagnoses (codes appear on superbills)
☐ Summary of psychosocial and psychiatric history and treatments
☐ Medical information, including the results of medical tests and medication
☐ Results of psychological tests
☐ Behavioral reports and observations
☐ Other _____

I understand that I may revoke this authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____	_____	_____
Client name	*Signature of client, parent, or legal guardian*	*Date*