Ellis McCauley, MS, LMFT
831-824-4540

Request to Release Confidential Information

Client's Name: _____

I authorize: _____

At _____

_____

Phone: _____

AND: Ellis McCauley, MS, LMFT

To release and exchange medical, psychiatric or substance abuse records and/ or information pertaining to my diagnosis and treatment. The medical records released by this authorization may be used for diagnosis, treatment, or insurance purposes. This authorization shall remain in effect until Ellis McCauley receives my written notice to terminate the authorization.

Date: _____ **Signature:** _____

Date of birth: _____