DISCOVERY
FAMILY SERVICES
DISCOVER. NURTURE. GROW.

AUTHORIZATION TO RELEASE/REQUEST INFORMATION

Patient's Name: _____ Date of Birth:_____

I, hereby, authorize _____ to

Release/request the below specified information to or from:

Discovery Family Services: Jose O. Alfaro, LMFT, License # LMFT106423
1805 W. Avenue K, Suite 203C, Lancaster, CA. 93534

This request and authorization applies to:

___ Healthcare records related to the following treatments, conditions, or dates:

_____

_____

___ All healthcare records.

___ Mental Health Records from dates: _____ to _____

___ Drug and/or alcohol treatment from dates: _____ to _____

___ Other:_____

_____

Patient's Signature:_____ Date Signed:_____

NOTE: This authorization expires on (date) :_____ or, if the patient exercises his/her right to voluntarily relinquish this authorization through a written request before the expiration date.