ACTS

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name: _____

Provider's Name: Marilyn Buzolich, Ph.D./ACTS Assocociates

Agency/Provider to whom disclosure is to be made: ACTS

Information or Records to be disclosed: (e.g. I.E.P., Psychology Evaluation, Neuropsychology Evaluation, Speech/Language Evaluation. Occupational Therapy, Physical Therapy Reports, Medical Summaries)

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As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of the patient's confidential health care, therapeutic records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

_____

Signature of Patient or legal representative

ACTS
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San Francisco, CA 94127

ACTS

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