

CONFIDENTIAL MEDICAL INFORMATION

COYOTE COAST

YOUTH AND FAMILY COUNSELING, INC. A LICENSED CLINICAL SOCIAL WORK GROUP.

ADMINISTRATIVE OFFICE: 104 CAMINO PABLO, ORINDA, CA 94563

INITIAL CONSULTATION & COUNSELING OFFICE: 110 CAMINO PABLO, ORINDA, CA 94563

PHONE/FAX: (925) 258-5400

CONSENT FOR EXCHANGE OF CLINICAL INFORMATION

I, _____ give permission for Coyote Coast to exchange
Name of patient or parent/guardian of minor patient

clinical and educational information regarding: _____

Name of patient (self or child)

with (name, relationship, phone #):

This consent provides for the exchange of oral and/or written information, including psychiatric, chemical dependency, educational, and medical information and is limited to clinical information necessary to provide good clinical care.

This consent shall expire one year from the date of signature. I understand that I may rescind this consent at any time with a written request to Coyote Coast stating that I do not give permission for further release or exchange of information.

I have carefully read, and I understand, the foregoing. I consent to the release of the above-specified information. I release Coyote Coast from any liability arising from the release of this information to designated persons or agencies.

Signature of Client or parent/guardian

Date

Print Name

I hereby certify that it is my opinion that said patient (parent/guardian) understands the nature of this release of information and is competent to give informed consent.

Signature of Coyote Coast Clinician

Date

Print Name