Psychiatric Patient Records Release

I, hereby authorize:

(client name)

(facility)

to disclose ANY and ALL RECORDS obtained in the course of my diagnosis and treatment during psychiatric visits to:

The Echo Company
P.O. Box 340927
Sacramento CA 95834
916-646-1936

The disclosure of ANY and ALL RECORDS authorized herein is required for litigation and related purpose.

This consent is subject to revocation by the undersigned at any time except in the extent of action had been taken in reliance hereon, and if not earlier revoked, it shall terminate:

Date:
Patient Name:
Patient Signature: ___________________________________
DOB:
SSN#:
Parent, Guardian, or Authorized Representative:
Name:
Signature: ____________________________________