Christopher Carstens, Ph.D.
Clinical Psychologist Psy 5654

9255 Towne Centre Drive, Suite 875
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(858) 455-5252

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La Mesa, CA 91941
(619) 698-9525

Instructions for Release Form

A. Please read the entire release form carefully. It gives me permission to share information with a specific person or organization.

B. Write the patient's full name on the line marked (1).

C. Write the name, address and phone number of the specific other person or organization with which I may share information in the box marked (2).

D. If you want to make any specific limitations on the information I share, write them on the line marked (3).

E. If the patient is 18 or over, the patient should print his or her name and sign on the line marked (4). If the patient is less than 18, the parent or guardian should print his or her own name and sign on the line marked (4). If you are a parent or guardian, please indicate your relationship to the patient on the line marked (5). Write "Parent" or "Guardian". Foster parents cannot sign medical releases for foster children.

F. If you have any questions about how to fill out this form, please call Dr. Carstens office at (619) 696-9188.

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Authorization Form

(1)Patient Name:_____

I/We authorize Christopher Carstens, Ph.D. and/or his administrative staff to release or exchange Protected Health Information about myself or my child(ren) with the following individuals or agencies. I also authorize the following agency or individual to release or exchange information with Dr. Carstens.

(2)[Other Professional's name, address and phone number here]

This release shall include any information, psychological, psychiatric, medical or social, which may pertain to my/our child(ren) or myself, including, but not limited to the following information : **School records and testing, medical records, psychological and psychiatric evaluation and records, with the following limitations:(3)_____**
_____.

For the following purpose: **Treatment planning and coordination.**

By signing this release, I recognize I am waiving any right of privacy between myself and the institution, agency, school, physician, other professionals or persons. This authority extends to the furnishing of copies of all or any desired parts of the records to the above-named person or persons. Unless otherwise specified, this authorization will be valid for two years (or_____) from the date it is signed. I have been informed that I can have a copy of this release. I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending writing notification of that revocation or modification to Dr. Carstens' office address. However, my revocation or modification will not be effective until Dr. Carstens receives it by certified mail. If I do this it will prevent any releases after the date it is received, but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal will not affect my ability to obtain treatment. I understand that I may inspect and have a copy of the health information described in this authorization.

I hereby release the named individuals from all legal liability that may arise from the release of the information requested. I affirm that everything in this form is clear to me and has been explained.

(4)_____ _____
Printed name and signature of client or Parent/Guardian Date
(5) Relationship to patient:_____