CLARITY
MENTAL HEALTH

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

I,_____ hereby authorize Dr. Yang at Clarity Mental Health to discuss my medical, psychiatric, alcohol, or drugs information contained in my records or disclose information with:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

FOR THE PURPOSE OF:
____ Continuation of Treatment ____ Coordination of Care ____ Application for Insurance

____ Legal ____Other (please specify)_____

_____ _____
Patient / Legal Representative Signature Date

_____ _____
Provider Signature Date

Clarity Mental Health
595 E. Colorado Blvd, Suite 505, Pasadena, CA 91101
Tel: (626) 869-7338, Fax: (626) 869-7383