



Empowerment Clubhouse

Authorization for Release of Information

I, _____, hereby give my permission or a mutual exchange of
(Print Applicant Name)

information between _____ and Marin City Community Development
(Facility or Other Treatment Provider)

Corporation with the knowledge that such contact discloses the fact that mental health services are being provided.

This disclosure is requested for proof of eligibility for services and appropriateness of services provided. The information shall be limited to diagnosis and safety. I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

This release is valid for one year from _____ to _____
(Date) (Date)

First Name: _____ MI: _____ Last Name: _____

SSN: _____ Date of Birth: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Applicant Signature: _____ Date: _____

STAFF USE ONLY:

Printed Staff Name: _____

Staff Signature: _____

Position: _____ Date: _____