

WIN
WESTSIDE INFANT – FAMILY NETWORK

**CONSENT FOR RELEASE OF CASE MGMT/PSYCHIATRIC/PSYCHOLOGICAL
INFORMATION RELEASE FROM WIN**

CLIENT NAME: _____

DOB: _____

I hereby authorize the Westside Infant-Family Network (WIN) at 5721 W. Slauson Ave., Suite 200, Culver City, CA 90230 to disclose case management/psychiatric/psychological information obtained in the course of diagnosis and treatment of the above named client from the agency named below to:

_____ Agency, Facility, Physicians, etc

_____ Address City State Zip

_____ Telephone Fax

Psychiatric records are protected by the California Welfare and Institutions Code, Section 5328. Disclosure shall be limited to the information specified below:

(CHECK APPROPRIATE ITEM(S) BELOW)

- | | |
|---|---|
| <input type="checkbox"/> Initial identifying intake information | <input type="checkbox"/> Results of psychological tests |
| <input type="checkbox"/> Initial evaluation/history/psychiatric reports | <input type="checkbox"/> Transfer/Termination Summary |
| <input type="checkbox"/> Diagnostic Exam Results | <input type="checkbox"/> Pertinent Discharge Summary |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> E-mail/Phone Communication |

The consent to disclosure may be revoked at any time, but revocation will not affect any action that has already been taken in accordance with the consent.

This consent, unless revoked, is valid for one year and will expire on

_____ Date

_____/_____/_____
Date

Signature of client

This form has been explained to the client in his/her own language.

Signature of Parent/Guardian/Conservator

Signature of Witness