

**WIN**  
**WESTSIDE INFANT – FAMILY NETWORK**

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

CLIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

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

\_\_\_\_\_ 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