AUTHORIZATION FOR RELEASE OF INFORMATION

Jeffrey Becker, MD, Inc.
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Santa Barbara, CA 93101

I authorize Jeffrey Becker, MD, Inc. to receive and release any and all personal and health related information to or from the following persons or treatment teams:

Practitioner Name	
Address	
Phone	
Fax	

Practitioner Name	
Address	
Phone	
Fax	

Practitioner Name	
Address	
Phone	
Fax	

CONSENT: Your signature below confirms you have read and understand the foregoing and consent to evaluation and treatment. I understand that this release authorizes disclosure of information regarding mental health, substance abuse, medical health, social history, treatment and other categories appropriate to care. I understand that I may revoke this consent at any time, but that it will stand unless I provide further notice.

_______________________________ _______________
Signature **Date**

____
Printed Name