

22330 Hawthorne Blvd., Suite 207 Torrance CA 90505 phone: 424.271.2933 www.archeuspsych.com admin@archeuspsych.com

## **AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION**

Ingram with not be held responsible	Client Signature	Date
	Client Signature	Date
esponsibilites and risks for securing	g the released PHI and Archeus Psychological As: e for any violation in confidentiality or breacl	
	ting this release to named entity, the patient and	
only the minimum doumentation	alid until midnight 60 days from signiture date n necessary for the specified release purpose ling a written request to Archeus Psychological As	. Patient may revoke this
□ All past and current	□ Specific date or range:	
Date Range of Requested Inform	nation:	
□ Documentation Requested: (I requests will be denied.)	Note: You must specify the documentation r	requested. "any and all"
□ Other (Specify):		
□ Diagnosis □ Treatment □	□ Court/Legal Purposes □ Work/Emplo	oyee Evaluation
Purpose(s):		
Address of individual/entity		
Telephone Number of individual/	/entity	
Name of individual/entity		
	er Protected Health Information (PHI) regard entity for the following purposes:	ding my treatment with
confidential information and other	rcheus Psychological Associates, Inc. and Dr.	Mark Ingram to exchar
confidential information and other		

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