Contact Release Form For Patients

I, the patient:

_____ _____ _____
Patient's First Name *MI* *Patient's Last Name*

Authorize The Solstice Clinic to contact my responsible party via the contact information provided below for the purposes of emergency contact as well as communicating/disclosing:

□ Information relating to payment and finances
□ Phone calls, phone messages & emails regarding session reminders
□ All Clinical Information
□ Emergency Contact

I understand that I have the right to revoke this confidentiality release agreement at any time during treatment, and that I must do so in a written document mailed to:

10921 Wilshire Blvd. Suite #412, Los Angeles, CA 90024

Responsible Party Contact Information:

Relationship to the patient: _____

Name: _____ _____ _____
First Name *MI* *Last Name*

Address: _____
Street name and number

_____ _____ _____ _____
Suite/Unit *City* *State* *Zip/Postal Code*

Phone Number: _____

Email address: _____

This authorization is valid for _____
Time period of authorization

_____ _____
Patient's Signature *mm/dd/yyyy*