Melinda Kincaid, LMFT (MFC49407)
4251 South Higuera Street, Suite 300
San Luis Obispo, CA 93401
805.294.3523

AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize Melinda Kincaid, LMFT (MFC 49407) to exchange the following information from the records of:

Name: _____

Birth Date: _____ SSN: _____

With: _____

Address: _____

Phone: _____ Fax: _____

I, _____, authorize the release of any and all of my personal records and information to Melinda Kincaid, LMFT (MFC 49407).

Extent and nature of information to be disclosed: Information pertaining to assessment and treatment of the client.

Purpose or need for information: Coordination of care and services.

I understand I may revoke this authorization at any time. I also understand that any information released prior to my revocation of this authorization shall not be a breach of my right of confidentiality. Further, I understand I have a right to receive a copy of this authorization.

This authorization is effective from the date of execution until _____(Date).

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

* A minor client's signature ages 12-17 years of age is required in order to release information concerning care for mental health conditions and or alcohol and drug abuse issues.