

INFORMATION RELEASE

TO:

Name of physician or referring agency

Street

City, state, zip code

I authorize you to release any or all medical or treatment information contained in the record of:

(Self/name of person and relationship)

TO: SANCTUARY PSYCHIATRIC CENTERS OF SANTA BARBARA
P.O. BOX 551
SANTA BARBARA, CA 93102

This information is required to assist Sanctuary House in determining admission to the program and/or type of treatment needed.

- Medical records
- Psychiatric evaluations
- Testing
- Admissions summary
- Departure summary
- Other

(Patient Signature/authorized representative signature)

Date

(Witness)

Date