



West Covina Medical Clinic, Inc.

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40(818) 960-8614

CONSENT FOR RELEASE OF ALCOHOL OR DRUG ABUSE PATIENT INFORMATION OR RECORDS

I hereby authorize _____
to disclose records obtained in the course of the diagnosis and treatment of

_____ (Name Of Patient)
for alcohol and / or drug abuse to _____
(Name Of Person Or Organization To Which Disclosure Is Made)

The disclosure of records authorized herein is required for the following purpose:

and such disclosure shall be limited to the following specific types of information:

This consent is subject to revocation by the undersigned at any time except to the extent
that the action has been taken, in reliance hereon, and if not earlier revoked, it shall
terminate on _____

(Date, Event, or Condition)

without express revocation.

Dated

Patient, Parent, Guardian, or Authorized
Representative of Patient

Printed Name
If signed by other than patient, indicate relationship:

Witness