Samuel Psychotherapy, INC
92 Argonaut, Suite 245
Aliso Viejo, CA 92656
(949) 887-8779

CONSENT TO OBTAIN MEDICAL RECORDS

I authorize Dr. Samuel to obtain medical records from the following:

TO: _____
NAME

_____
ADDRESS

_____
CITY STATE ZIP CODE

This information is to be disclosed without any limitation. This consent will end one year from the date of signature.

_____ _____
PRINT NAME DATE OF BIRTH

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE