

**MICHELLE HOBBY, Ph.D.**

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**CONSENT/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ of \_\_\_\_\_  
Name of client address

\_\_\_\_\_  
city, state, zip

authorize the release or exchange of information between **Michelle Hobby, Ph.D.** and

\_\_\_\_\_  
Name of individual or organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone/Fax numbers

The following information is to be released:

- |                   |                          |                    |                          |
|-------------------|--------------------------|--------------------|--------------------------|
| Treatment history | <input type="checkbox"/> | Test results       | <input type="checkbox"/> |
| Treatment summary | <input type="checkbox"/> | School history     | <input type="checkbox"/> |
| Treatment plan    | <input type="checkbox"/> | Family history     | <input type="checkbox"/> |
| Discharge summary | <input type="checkbox"/> | Medication history | <input type="checkbox"/> |
| Other _____       | <input type="checkbox"/> |                    |                          |

The information is to be released for the following reason(s): \_\_\_\_\_

I understand that my records are protected under Federal and State confidentiality regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this authorization is effective immediately and I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event the consent expires in 1 year unless I renew it. I further acknowledge that this information to be released was fully explained to me, this consent is given of my own free will, and I release the clinician Michelle Hobby Ph.D. from any liability arising from the release information presented to the persons/agency designated above.

Specification of date, event, or condition upon which this consent expires: \_\_\_\_\_ or 1 year from date signed.  
A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Signature of witness