Wellness Center Referral Form

Attn: Dr. Eval Gal-Oz
Please Fax this form to **Fax:** (408) 869-9172 **or call** **Phone*:** (408) 869-9160

Referring Individual Name:___________________Phone:______________
Agency:____

Client Information:
Name:_______________________________________ Phone:___________
Address:____Apt.___________
City:__________________________State:_____ Zip code:_______________
Language spoken:____________________email: ________________________
Insurance ____yes____no
Reason for Referral:
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Authorization to release information by client
I, _______________________________,(“client”) hereby authorize ___________________ , (hereinafter “referring agency”) to disclose mental health treatment information and records obtained in the course of interviewing, including, but not limited to, diagnosis of Patient, to:
Dr. Eval Gal-Oz, Clinical Psychologist, at the **Goodwill Wellness Center.**
I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless agency has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Referring Agency _________________at **Address of Referring Agency______________________________ ___________________________________,** to be effective.
This disclosure of information and records authorized by Interviewee is required for the following purpose: 1) consideration for therapy or counseling or 2) consideration for psychological assessment.
Therapist shall not condition treatment upon interviewee signing this authorization and interviewee has the right to refuse to sign this form.

This authorization shall remain valid until: ________________________(Please don’t put today’s date)

Client’s signature: ______________________________Date:_____________________

*If referring individual prefers to call the center directly for scheduling, no information will be discussed except contact information of client, unless we receive the authorization signed by fax.

1080 North 7th Street, San Jose, CA