



# AUTHORIZATION FOR RELEASE OF MEDICAL AND PSYCHIATRIC PATIENT RECORDS AND INFORMATION



**Parks & Recreation Department**  
Adapted Programs  
620 Laguna Street  
Santa Barbara, CA 93101  
(805) 564-5421  
[www.sbparksandrecreation.com](http://www.sbparksandrecreation.com)

**PARTICIPANT (PATIENT) NAME** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Social Security Number (optional)** \_\_\_\_\_

**I, the undersigned, hereby authorize:**

**Physician or medical facility name** \_\_\_\_\_

**Name of participant's school district if participant is a minor** \_\_\_\_\_

to release records and information developed in the course of the diagnosis and treatment of the patient listed above, including medical and psychiatric records, to the City of Santa Barbara Parks and Recreation Department.

This disclosure of medical records and/or information is for the purpose of evaluating the patient's participation in recreation programming offered by the City of Santa Barbara Parks and Recreation Department and to determine what conditions, restrictions or accommodations, if any, are warranted for the patient's participation.

This release shall become valid immediately and shall remain in effect for the length of the patient's participation in the recreation program.

A copy of this authorization shall be as valid as the original. The undersigned has a right to receive a copy of this authorization if a copy is requested.

**Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:**

✓ **Signature** \_\_\_\_\_ **Print Full Name** \_\_\_\_\_ **Date** \_\_\_\_\_