

**Michael H. Foust, Ph.D.**  
**540 Golden Circle Drive, Suite 211**  
**Santa Ana, CA 92705**

**Release of Information for Outpatient Psychotherapy Records/Information**

**Continuity of Care**

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I, \_\_\_\_\_ (Name of Patient)

authorize **Michael H. Foust, Ph.D.** (Dr. Foust) to release my complete medical chart, inclusive of my contact information, chart notes, and prescription records to a licensed mental health profession associated with Practice-Legacy Programs™ (P-LP) upon Dr. Foust's death, or other event, that renders him unable to practice as a my psychologist.

II. I understand that the confidential information provided to P-LP will not be used for any purpose other than its intended use: To aide in the continuity of my mental health care and treatment to a referral psychologist previously agreed upon between me and Dr. Foust

III. Dr. Foust is not authorized to disclose any of my confidential information to any other person or entity without my consent.

**Continuity of Care Provision**

IV. I have been informed by Dr. Foust of his participation with P-LP which ensures the continuity of my mental health care/therapy in case of an unanticipated or emergency situations rendering Dr. Foust unable to continue with my care, therapy, or treatment.

I hereby authorize and consent that the contents of my mental health chart maintained by Dr. Foust, upon his inability to practice, be made available to a licensed mental health professional associated with P-LP, upon the termination of Dr. Foust's practice. That individual will review, assess, and ensure my referral to another qualified mental health professional, of my choosing, without further written consent on my part.

I understand that by signing this Continuity of Care Provision that I am knowingly, intelligently, and voluntarily waiving my patient-therapist right of confidentiality to enable the continuity of my care. This release applies only to a licensed mental health professional associated with P-LP.

V. I understand that I may revoke this authorization, in writing, in whole or in part, at any time.

Name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness : [print name] \_\_\_\_\_ Signature: \_\_\_\_\_