

# Goodwill Wellness Center



**GOODWILL**  
*of Silicon Valley*

Mental Health Clinic

(408) 869-9160

Open Monday  
through Friday

9am to 4pm

We provide

- Free Therapy Sessions
- Free Addiction Counseling
- By Referral only, to  
Individuals without  
Insurance

*Goodwill Industries of Silicon Valley*

**1080 N. 7<sup>th</sup> Street, San Jose, CA 95112**



# GOODWILL

of Silicon Valley

## Wellness Center Referral Form

Attn: Dr. Eval Gal-Oz

Please Fax this form to Fax: (408) 283-9093 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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.