CONSENT TO RELEASE INFORMATION

RE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name

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

Client Date of Birth

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Melanie Gonzalez, LMFT #116208, name of client/guardian for client to exchange information with

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

*name, title, phone number and email address*

regarding mental health and other related services being provided, including, but not limited to: the client’s mental health, social, emotional, occupational, academic, amongst other areas of functioning and any medical issues pertaining to mental health. This exchange of information is for the purpose of better, more extensive and comprehensive treatment planning, implementation and evaluation and the comprehensive coordination of care that is in the best interest of the client.

I understand that this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration date.

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Signature of authorizing party Date

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

Signature of authorizing party Date

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Therapist Signature Date