AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client's Name:

SoCal Therapy Center may

☐ Release Information To and/or ☐ Receive Information From

Name:			
Address:			
Phone:		Fax:	
Email:			

Information to be Released or Exchanged:

- ☐All Records
- ☐Medical History & Physical Exam
- ☐Psychiatric Evaluation
- ☐Psychological Test Results
- ☐Diagnoses
- ☐Family Systems Evaluation
- ☐Educational Records
- ☐Educational Tests and Reports
- ☐Attendance Records
- ☐Psychosocial Reports
- ☐Lab Results

Other (specify) Click or tap here to enter text.

This release is an active authorization until revoked by me in writing.

_____ _____

Signature of Client, Parent or Guardian Date