# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize_____
doctor, therapist, school agency, etc.

_____
street address city state zip

and
Family Consultation Services

_____
therapist

to exchange all pertinent records and information concerning the psychological and/or medical history with each other regarding the below listed client. This release shall remain in effect for six months and may be revoked in writing by the undersigned at any time.

_____ _____
Name of Client Date of Birth

_____ _____
Signature Date Signed

_____ _____
Name of Client Date of Birth

_____ _____
Signature Date Signed

_____

2525 Camino del Rio S, Ste 315 San Diego CA 92108 (619)280-3430 FAX (619)280-5420

Relationship to Client

_____

**I would like a copy of this release ☐ yes ☐ no**