Mt. Diablo
PSYCHOLOGICAL SERVICES

Beth Christensen, LMFT
Elizabeth Rauch Leftik, Psy.D.
Susan P. Williams, LMFT
Sarah E. Wood, Ph.D
Rupa Zimmermann, Ph.D.

Release of Confidential Information

Client Name: _____ DOB: _____

I authorize members of Mt Diablo Psychological Services to:

_____ **Obtain protected information from**

and/or

_____ **Provide protected information to:**

Name: _____

Address/Telephone: _____

E-mail: _____

I authorize the release of information for the following purposes:

(Please circle) Treatment Planning Continuity of Care

Other (describe): _____

I authorize the release of the following information:

(Please Circle) Consultation Psychological Reports Clinical Notes
Medical of Hospital Records School Records

Other (describe): _____

This authorization shall remain in effect until _____, or one year following the date on this form. This authorization may be revoked in writing at any time.

_____
Client Name

_____ _____
Signature of Client/Parent/Guardian Date