Mt. Diablo

PSYCHOLOGICAL SERVICES

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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