AUTHORIZATION TO RELEASE / EXCHANGE INFORMATION

Name of Client:

Date of Birth:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby authorize TRUTH FAMILY AND CHILD COUNSELING SERVICES, INC., C/O LAURA MONDRAGON, LMFT, CCTP (hereinafter “Provider”) to disclose / exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist’s diagnosis, of the client listed above

to:

I am requesting this disclosure of information and records for the following purpose: Any

 and all information necessary Treatment Plan Prognosis Diagnosis

 Clinical Test Results Date of Treatment Progress to Date

 Summary of Treatment Other:

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

Unless otherwise revoked, this authorization will expire in: six months one year other:

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

Signature of Client: Date:

Signature of Legal Guardian: Date:

Relationship to Client: Date: