



"Life is comprised of continuous opportunities to practice."

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Authorization for Release of Information by Client (in client's handwriting)

By signing this document, I (Name of Client) _____

hereby authorize (Name of Provider or Agency) _____

to disclose information and records for the purpose of my diagnosis and/or treatment of the above client.

I understand that I have a right to receive a copy of this authorization; I also understand that any cancellation or modification of this authorization must be in writing.

This disclosure of information and records authorized herein is required for the following purpose: _____

The specific uses and limitations on **WHO** this information will be disclosed to is as follows:

Such disclosure shall be limited to the following specific types of information:

This authorization shall remain valid until: _____ Today's Date: _____

Signature (of client): _____