Wendy Mosqueda, M.A.
Licensed Marriage and Family Therapist

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

I hereby authorize the exchange of information between_____and _____. Regarding_____.

I give permission to exchange the following information:

___Medical
___Psychiatric
___Psychological
___Progress in treatment
___Education
___Social
___Legal
___Other_____

This authorization is valid for one year from the date specified below, or when treatment is completed/terminated. I also understand this information may not be released to any other person and/or organizations without my permission in writing. A photocopy or fax of this authorization can be considered valid.

_____
Printed Name

_____
Signature of Parent or Legal Guardian (if client is a minor).

_____
Client Signature

_____
Wendy Mosqueda, M.A., MFT

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