La Vida Life Counseling Center

1850 E. 17th'Street. Suite119, Santa Ana, CA 92706 (714) 888-9156

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION :

This form cannot be used for the re-release of confidential information provided to ***La Vida Life Counseling Center*** by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, ______ (DOB ______) authorize

La Vida Life Counseling Center Staff/Therapist: ______ to:

☐ release to ☐ obtain from ☐ exchange with

Person's Name: ______

The following information pertaining to the student/client:

☐ treatment summary
☐ history/intake
☐ diagnosis
☐ psychological test results
☐ psychiatric evaluation/medication history
☐ dates of treatment attendance
☐ therapy in class/school
☐ other (specify): ______

For the purpose of:

☐ evaluation/assessment and/or coordinating treatment efforts
☐ mental health services
☐ other (specify) ______

This consent will automatically expire one (1) year after the date of my signature as it appears below, ______

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Name of Client	Signature of Client	Date

Name of Witness	Signature of Witness	Date