# Authorization for Release of Information

Client Name ____________________________________________________________

Date of Birth ___________________

I authorize the exchange of medical, psychological, legal, therapeutic, and/or educational information between The Center for Connection and:

| Name | Address | Phone/Fax | Email | Permission to receive information | Permission to release information |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Purpose of Communication:

________________________________________________________________________

I understand that this authorization for the release/receipt/exchange of information will be valid until revoked in writing.

Signature of Patient _______________________________________________________

Date________________

Signature of Parent/Guardian_______________________________________________

Date________________

275 E CALIFORNIA BLVD, PASADENA, CA 91106 -- 626.365.1211
INFO@THECENTERFORCONNECTION.ORG