# Consent for Release of Information

Patient Name: ______________________________

Date of Birth: ________________

This release of information form authorizes information from my records regarding diagnosis, symptoms, and treatment to be shared between Elizabeth Winkler, LMFT, and the person, school, or agency listed at the bottom of this form. By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this authorization to be valid.

I understand that this authorization is valid for one year from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Name, Agency, School, or Individual: ____________________________________

Street Address: _______________________________________________________

City: _________________________________ Zip: ________________________

Phone Number: _________________ Email Address: ______________________

Signature of Parent, Guardian, or Client: __________________________________

Date: ________________________

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