SUNSHINE
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THERAPY

Authorization Consent and Release of Information

I, _____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Date of Birth

_____
Telephone and Fax Numbers

Hereby authorize and/or request a release of information between Ivonne Garcia, LCSW and:

_____
Person or Agency

_____
Street Address

_____
City, State, Zip Code

_____
Telephone/Fax Numbers/Email

_____

The specific information to be exchanged/released includes the following (as initialed by me):

You get to decide what to write here (e.g. all clinical content, information about risk, how many sessions I attended, general prognosis, diagnosis, treatment recommendations, etc.): _____

For the purpose of:

You get to decide what to write here too (e.g. coordinating care with other professionals, to help my family/friend/etc. know how to support me):

_____

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I understand that I can revoke this request and authorization at any time. I also understand that this authorization expires one year from todays date unless otherwise indicated by you and initialed here: _____(alternative date of expiration).

Printed Name of Client: _____

_____ _____

Signature of Client Date