Pete McClintock M.A., LMFT
325 W. Washington St. Suite 2254
San Diego, CA. 92103
(619) 299 0975

CONSENT TO RELEASE INFORMATION

_____ _____

NAME **DOB**

I hereby request and authorize Pete McClintock M.A. LMFT to release information regarding my psychological and/or medical history to:

_____

NAME OF PARTY WITH WHOM RECORDS/INFORMATION WILL BE SHARED

_____

DESCRIPTION OF INFORMATION TO BE SHARED

{ } I agree that the above part with whom my records will be shared can release Information about me to Pete McClintock M.A., LMFT.

This authorization will expire two years from the date below Unless otherwise noted.

Alternate expiration date:. _____

_____ _____

CLIENT OR GUARDIAN'S SIGNATURE **DATE**