Pete McClintock M.A., LMFT
3344 4th Ave. Suite 200
S.D. 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 party to whom my records will be shared can release information about me to Pete McClintock M.A., LMFT.

This authorization will expire one year from the date below unless otherwise noted.

_____ _____
Client or Guardian's Signature **Date**