

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Client's name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
I \_\_\_\_\_ or \_\_\_\_\_  
Name of Patient Parent/Guardian

Hereby authorize \_\_\_\_\_  
Name of person/agency

Address \_\_\_\_\_  
(Street, City, State, Zip)

To release/and/or exchange professional and/or medical information regarding my child and/or myself to:

Margaret Grundstein, MFT  
11340 W.Olympic Blvd, Ste. 381  
Los Angeles, Ca. 90064

Information to be disclosed pertaining to the assessment and/or treatment of the following conditions (check pertinent boxes)

\_\_\_\_ Medical \_\_\_\_ Drug \_\_\_\_ Alcohol \_\_\_\_ Psychiatric \_\_\_\_ School

and should be limited to the following types of information:

\_\_\_\_ Diagnosis \_\_\_\_ Discharge Summary \_\_\_\_ Psychiatric Evaluation \_\_\_\_ Progress Notes  
\_\_\_\_ Psychological Test Results \_\_\_\_ Educational \_\_\_\_ Assessment \_\_\_\_ Behavioral Reports  
\_\_\_\_ Other

The disclosure is required for:

\_\_\_\_ Evaluation \_\_\_\_ Treatment \_\_\_\_ Other

This authorization is effective from \_\_\_\_/\_\_\_\_/\_\_\_\_ and maybe revoked at any time by the undersigned. This authorization is good until \_\_\_\_/\_\_\_\_/\_\_\_\_.  
I understand I have the right to receive a copy of this authorization.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
(Street, City, State, Zip)

Parent/Guardian Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

**Adult, Child  
and Family Therapy**  
11340 W. Olympic Blvd.  
Suite 381  
Los Angeles, California  
90064