SWANSON PSYCHOLOGY, INC.
A Psychological Corporation

ENCINO MEDICAL PLAZA
5400 BALBOA BOULEVARD, SUITE 311
ENCINO, CALIFORNIA 91316
TEL.: (626) 470-3568

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, ______________________________, do hereby give permission to Brian Swanson, Psy.D, J.D., licensed clinical psychologist, to release information to and to receive information from the party described below:

____
Name

____
Organization

____
Street Address

____
City, State and Zip Code

____________________ ____________________
Telephone Number Facsimile Number

I understand that this exchange of information will only pertain to my treatment. I also understand that this authorization will be considered void immediately upon my request in writing, one year after the date I have signed it or at which time treatment is terminated (whichever shall occur first).

____
Client's Name Printed

____ ________________
Client's Signature *Date*

____ ________________
Legal Guardian's Signature (if client is a minor) *Date*

Confidential