



ADA Monitored Family Visitation Services

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Brea, CA 92821

www.ADAmonitoredFamilyVisitationServices.com

adamonitor@gmail.com

714-752-0091 alternate number 909-730-6483

Authorization for Release of Confidential Information

I, _____ hereby authorize
(Print Name of Parent who records will be communicated)

Dr. Angela De Pass Albers to:

Release Receive Exchange

the following information:

Full Record Summary Case Review

with the following persons or organizations:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| _____ | _____ |
| _____ | _____ |
| 2. _____ | 4. _____ |
| _____ | _____ |
| _____ | _____ |

I have carefully read, and I understand the foregoing. I consent to the release of information as marked. I acknowledge that I understand the type of information that is being released, as well as, the benefits and disadvantages of releasing this information. I understand that I may receive a copy of this notice upon request. This release shall terminate in one year. I agree that a Photostatic copy of this notice is as valid as the original.

Signature:

Parent

Date

Legal Representative
(Sign here only if you are NOT the parent)

Relationship

Date