Diana Valdez, PhD, LPC

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Authorization for Release of Information

_____ _____
Client Name Date of birth

I authorize Dr. Diana Valdez to release and/or exchange information with:

_____

the following information about me:

____ Two way verbal communication
____ Medical evaluation/diagnosis
____ Psychiatric Evaluation
____ Psychological Testing and Reports
____ Chemical Dependency Evaluation
____ Progress Notes
____ Treatment Planning
____ Other: _____

The purpose of this disclosure is: _____

I understand that the information will not be disclosed to other sources unless specifically authorized by law or my written consent. I understand that I may refuse to release this information and the consequences of this refusal have been explained to me.

I understand I may revoke this consent at any time; that revocation must be in writing; and revocation does not affect action taken on this consent prior to the revocation.

I understand this consent will automatically expire in one year from the date of signature, unless otherwise noted.

_____ _____
Client Signature (Parent/Guardian if a minor) Date

_____ _____
Therapist Signature Date

Revised 02/12/2015