Joe Puentes, Psy.D.
Licensed Psychologist, PSY 25330

Authorization to Release Information

I, _____ (Client Name), authorize the disclosure of my mental health treatment information and records obtained in the course of treatment between the parties listed below:

_____

_____

_____

and:

Joe Puentes, Psy.D.

I have signed this form to authorize the exchange of information between the parties listed above. I understand that I have the right to receive a copy of this form, and that I must submit any cancellation or modification of this authorization in writing to Joe Puentes, Psy.D. I also understand that I have the right to revoke this authorization at any time unless Dr. Puentes has taken action in reliance upon it. I understand that I have the right to refuse to sign this form, and Dr. Puentes shall not condition treatment upon my signing of this authorization.

This authorization shall remain valid through: _____

Client Signature: _____ Date: _____

Parent/Gaurdian Signature:_____ Date: _____

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