Silicon Valley PSYCHOLOGY

901 Campisi Way, Suite 150
Campbell, CA 95008
408-772-5378

Authorization for Release of Information

Client name: _____ Date of Birth: _____

Client Address: _____ Social Security #: _____

_____

Parent/Guardian name (if client is a minor): _____

By my signature below, I hereby authorize the person(s) indicated below to exchange information with Silicon Valley Psychology, regarding me or my child for purposes related to treatment. I authorize Silicon Valley Psychology to release clinical records and information pertaining to my mental health history, treatment, and services to the person(s) indicated below.

Name(s): _____

Organization: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Silicon Valley Psychology, unless I request otherwise. I understand that I may withdraw this consent at any time. If withdrawn, I understand that Silicon Valley Psychology may not further use or disclose my clinical information, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Client/Parent/Guardian Signature: _____

Client/Parent/Guardian Name (printed): _____

Date: _____