Tamara Wade LCSW
800 Pollard Rd. Ste. B 201
Los Gatos, CA 95032
(408) 666-3512
twadetherapy.com

AUTHORIZATION TO RELEASE INFORMATION

I, (parent/guardian/client) _____, hereby authorize Tamara Wade LCSW. (hereinafter "Provider") to exchange mental health treatment information and records obtained in the course of therapy of (patient)_____, including, but not limited to, this therapist's diagnosis of patient, to:

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **800 Pollard Rd. Ste. B 201, Los Gatos, CA 95032** to be effective.

This disclosure of information and records authorized by parent/guardian is required for the following purpose: _____

The specific uses and limitations of the types of medical information to be discussed are as follows:

_____

_____

This authorization shall remain valid until: _____

Signature: _____Date: _____
(*parent/guardian/client)

Signature: _____Date: _____
(*parent/guardian/client)
*Please have both parents and/or guardians sign this form, if the client is a minor. If the parents or guardians are separated or divorced, both signatures are required.