AUTHORIZATION TO RELEASE INFORMATION

Select One:

☐ **Skyline College** ☐ **Cañada College** ☐ **College of San Mateo**

The confidentiality of this record is required under California General Statutes. This material shall not be transmitted to anyone without consent or authorization as provided in the statutes.

I, _____hereby authorize
(client)
_____ to ***release and exchange*** information between
(Name)_____and function (chooses one)

☐ **Trainee**: Marriage and Family Therapist trainee, Clinical Counselor trainee,

☐ **Associate**: Associate Marriage and Family Therapist (AMFT), Associate Clinical Social Worker (ASW), Associate Professional Clinical Counselor(APCC)

☐ **Licensed**: Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC)

and _____.
(contact name and function)

This information will be used for the specific purpose of counseling treatment. Specify type of information to be released:

Any/All		Treatment Plan		Prognosis	
Diagnosis		Dates of Treatment		Client Records	
Summary of Treatment		Other			

I understand that the records and information to be released may contain information pertaining to psychiatric, drug and/or alcohol treatment and may contain confidential HIV/AIDS related information._____
(client signature)

This authorization will expire on ___/___/_____ (1 year from the date of signature). I also understand that this authorization may be revoked by me, in writing, at any time, except to the extent that action has already been taken and that I have the right to receive a copy of this authorization.

_____ _____

(printed name of client) (date of birth)

_____ _____

(signature of client) (date)