



MELANIE REYES, MA, LMFT

Licensed Marriage and Family Therapist, 92642

(949) 424-3717

LivesRenewedCounseling@gmail.com

MelanieReyesCounseling.com

LIVES RENEWED COUNSELING SERVICES

594 North Glassell St. | Orange, CA 92867-6748

Authorization for Release of Information

Date: _____

Client Name: _____ Client Email: _____

Client DOB: _____ Client Phone Number: _____

Client

Address: _____

I, _____ authorize the parties below to release to each other confidential information about me or my child _____, including but not limited to history, functioning, symptoms, diagnoses, treatment, prognosis, etc. for the purpose of

_____.

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

This consent shall be valid from _____ to _____. I understand that I may revoke this Release of Information, in writing, at any time, except to the extent that it has already been acted upon. A photocopy, email, fax of this release is to be considered as valid as the original.

I hereby release the parties named above from any liabilities for release of this information.

Signature of Client (or Parent or Guardian of Client if Client is a minor): _____ Printed Name: _____

Date: _____