



Client's Name: _____

I, _____
Name of Client

hereby authorize _____
1124 Bay Boulevard, Suite D, Chula Vista CA. 91911), to release and

Name of Person/Agency/Addr

INFORMATION DISCLOSED SHOULD BE

- Diagnosis
- Psychological Evaluation
- Medical Issues
- Client File
- School Issues

**This authorization will be valid for a year from the date specified :
completion/termination from the program. I also understand that
written request of termination to South Bay Community Services.**

Client's Signature _____ Date _____

Witness _____ Date _____

Authorization To Release Client's Information

_____ D.O.B: _____

or _____
Name of Parent or Guardian

_____ (Staff member at South Bay Community Services,
obtain information regarding my child and/or myself to:

Address/Telephone Number

≡ LIMITED TO ISSUES REGARDING

- Behavioral Reports
- Psychiatric Evaluation
- Legal Issues
- Case Consultation
- Other _____

**after our signatures, or until the time of my
I may revoke this authorization at any time, by providing a**

Parent/Guardian's Signature Date

Other Parent/Guardian Date