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 a completion/termination from the program. I also understand that written request of termination to South Bay Community Services.

_____
Client's Signature Date

_____
Witness Date

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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:

_____
ess/Telephone Number

E 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

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