



DEBORAH C. WEISBERG

— LMFT, LPCC —

## Consent for Release of Information

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

This release of information form authorizes information from my records regarding diagnosis, symptoms and treatment to be shared between Deborah Weisberg, LMFT, LPCC and the person, school or agency listed at the bottom of this form. By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this authorization to be valid.

I understand that this authorization is valid for one year from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

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Name, agency, school, or individual

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Street address

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City

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Zip

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Phone number

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Email address

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Signature of parent/guardian/client

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Date