**Amy Gallardo, LMFT**

**Licensed Marriage and Family Therapist**

**#45986**

**Authorization for the Release of Information**

|  |  |  |
| --- | --- | --- |
| Re: | |  |
| (Client/Youth’s Name) | | DOB |
| I hereby authorize: | | |
| (Name & Address of Person/ Agency) | | |
| to exchange information/release the records with/to the attention of Amy Gallardo, Licensed Marriage and Family Therapist. This authorization may be revoked in writing at any time and will expire in one year from the date of signature below. Any re-disclosure of information by the recipient is prohibited without the express written consent of the client/parent/guardian listed below. This release includes all educational, psychological and medical records.  I have carefully read and do understand this release request, and I consent to the release to the specified person(s) or agencies listed. | | |
|  |  | |
|  | | |  |
| Authorized Signatures | | |  |
| |  |  |  | | --- | --- | --- | |  |  |  | | (Print Client’s Name) | *(Signature- over 12)* | (Date) | |  |  |  | | (Print Parent/ Guardian Name) | (Signature) | (Date) | | | |  |
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