Rebekah F. Balboni, LCSW
(510) 499-7197

Consent to Exchange Information

Client Name: _____

Date of Birth: _____

I authorize Rebekah Balboni, LCSW to exchange information with

Name: _____

Address: _____

The information to be released from my records, or those of my child named above, may include the following:

_____ **Psychological**

_____ **Medical**

_____**Diagnostic**

I understand that this authorization may not be released to any other party or organization without my permission. A photocopy of this authorization shall be considered valid.

_____ _____

Client signature (Parent or Guardian if minor) **Date**

_____

Address **City/State** **Zip**