

Growing Connections
P. O. Box 50205, Irvine, CA 92619
(714) 624-2240

Consent to Release Client Records/Information

Name of Client: _____ Date of Birth: _____

Address: _____

I hereby authorize the following specified individual(s) or organization to **exchange** records or information with Kimberly Akamine, LMFT, my counselor at Growing Connections. This authorization is limited to information concerning myself which has been acquired in a professional capacity and which may be deemed necessary for the purpose of assessment, treatment, or insurance payment.

Examples of specified individuals or organizations:

- For a specified physician, psychologist, counselor, or mental health facility I authorize release of any medical or psychological records or information.
- For a specified school and any teacher, counselor, or administrator thereof, I authorize release of records or information regarding my school attendance, academic performance and behavior as well as pertinent test results.
- For a specified insurance carrier I authorize disclosure of myself as a client, diagnosis, treatment dates, treatment plan, treatment cost, and progress reviews.
- For a specified pastor, family member, or friend I authorize exchange of information that may be pertinent to my treatment, safety, and emotional well-being.

Name of Individual or Organization	Phone Number	
Address		
City	State	Zip

This consent may be revoked by the undersigned by providing written notice.

Signature of Client	Date
Signature of Client	Date
Signature of Parent/Guardian	Date