



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

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

## 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:

\_\_\_\_\_  
Address/Telephone Number

### ≡ 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