Authorization and Request for Release of Mental Health Records

CLIENT NAME: ____

CLIENT BIRTHDATE: __________________________________

I, ______________________________, the undersigned, do hereby request the release to:

____________________________________, Hayutin & Associates, 2500 Santa Monica Blvd, Suite 100, Santa Monica, CA 90404, of the information and records maintained by:

(Name) ____

(Address)____

(Phone) ____

With respect to treatment and services (including mental health treatment and services) rendered to my minor child. This permission shall be in effect for a period of twelve months from the date signed below for the purpose of discussing my child's emotional and educational needs, and how to best support my child through tutoring or educational therapy sessions.

____
Printed Name of Parent or Guardian

____________________________________ ___________________
Signature of Parent or Guardian Date

____
Specify Relationship to Client