aaron airozo, ms, mft (mfc # 46599)
2222 Watt Ave, Suite #D6, Sacramento, CA 95825
(916) 549-9844

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, Date of Birth_____

Hereby authorize and request Aaron Airozo, MFT (MFC # 46599) to

☐ Release Information to ☐ Obtain information from

Name: _____

Title: _____

Phone: _____

Concerning client: _____

For the following information:

__ Entire Record
__ Diagnosis
__ Psychiatric Evaluation
__ Neurological Assessment
__ Individual Treatment Plan
__ Medical Information
__ Lab Test Results
__ Legal Information
__ Results of Psychological/Vocational Test (including raw data)
__ Discharge Summary
__ Telephone Conference
__ Treatment Summary
__ Other:_____

The above information may be exchanged orally or in writing. This authorization is given of my own free will and is in effect for six months from the date below. I understand that I can revoke this authorization in writing at any time.

Signature_____ Date_____

Signature_____ Date_____
(Parent or Guardian of Minor)

Therapist's signature _____ Date_____

Reference: California Civil Code Section 56.11