Authorization to Use or Disclose Information

Client Identification Information:

_____
Client Name

_____
Date of Birth of Client

This information is to be disclosed to:

PlusFour Solutions
ATTN: Stephen G. Newton, Ph.D.
Licensed Clinical Psychologist, PSY13259
851 Fremont Avenue, Suite 103
Los Altos, CA 94024
(650) 949-2439 Fax
(650) 949-2440 Telephone
snewton@plusfoursolutions.com

I authorize:

_____
Name of school, professional, physician, mental health provider, clinic, agency, or attorney

_____
Address, City, State, Zip code

_____
Email address

_____ _____
Phone Number Fax Number

To disclose the following information:

- □ Academic Records
- □ Psychological Assessment
- □ Telephone Consultation
- □ School Records / Contact with School Personnel
- □ Medical Records
- □ Psychiatric Records
- □ Other: _____

Dates to be released:

□ All dates □ From _____ to _____

_____ _____
Signature of Client / Guardian Relationship to Client

☐ Client is a minor child

_____
Date

NOTE: This authorization is valid for 12 months, unless otherwise stated by Client.
Authorization may be revoked in writing at any time.
A copy of this authorization is as valid as the original.
Client has the right to a copy of this authorization at any time.