



Anchor Psychology, Inc.
 1975 Hamilton Ave.
 Suites 11 & 37
 San Jose, CA 95125

main: 408.340.5875
 anchorpsychology.net

AUTHORIZATION FOR RELEASE OF INFORMATION

Client name: _____ Date of Birth: _____

Client Address: _____ Social Security #: _____

Parent/Guardian name (if client is a minor): _____

By my signature below, I hereby authorize the person(s) indicated below to exchange information with Anchor Psychology, Inc., regarding me or my child for purposes related to treatment. I authorize Anchor Psychology, Inc. to release clinical records and information pertaining to my mental health history, treatment, and services to the person(s) indicated below.

Name(s): _____

Organization: _____

Address: _____

Phone Number: _____

Fax Number: _____

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Anchor Psychology, Inc., unless I request otherwise. I understand that I may withdraw this consent at any time. If withdrawn, I understand that Anchor Psychology, Inc. may not further use or disclose my clinical information, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Client/Parent/Guardian Signature: _____

Client/Parent/Guardian Name (printed): _____

Date: _____