

## AUTHORIZATION TO RELEASE/RECIEVE HEALTHCARE INFORMATION

**Client Name:**

**Date of Birth:**

I request and authorize **Tobias Desjardins, LCSW** to  
release the healthcare information for the client named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Protected healthcare information including assessment, diagnosis, care plan, discharge recommendations,  
psychological testing, medical, neurological, lab testing, medications, and progress reports, and \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This authorization becomes effective \_\_\_\_/\_\_\_\_/\_\_\_\_. This authorization may be revoked by the undersigned at anytime except to the extent that action has already been taken. If not revoked this authorization shall terminate one year from the date of authorization.**

Client Signature:

Date Signed:

Parent or Guardian:

Date Signed:

Tobias Desjardins:

Date Signed:

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**Confidential Client Information – See California W& I Code Section 5328**

*Tobias Desjardins, LCSW – (888) 288-1614 online @ [www.WhatIsCoparenting.com](http://www.WhatIsCoparenting.com)*