JOHN F. KENNEDY UNIVERSITY
Office of Clinical Training | College of Psychology
100 Ellinwood Way, Pleasant Hill, CA 94523 | (925) 969-3444

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, (*name of client*)_____hereby authorize the Office of Clinical Training at John F. Kennedy University to release confidential information regarding my treatment with the following person or entity:

Name of Agency: _____

Specific Person/Department: _____

Position/Relationship: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

I authorize the release of the following information about me:

☐ Dates of Treatment ☐ Diagnosis ☐Treatment Plan

☐ Progress Notes ☐ Clinical Test Results ☐ Entire Psychotherapy Record

☐ Other_____

I authorize the release of the information described above for the following purpose(s):

(Be as specific as possible, e.g.: to verify my treatment, help me obtain benefits)

Rev. 7/18

The recipient may use the information described above solely for the following purpose(s):

(Be as specific as possible, e.g.: to determine my eligibility for their program)

I understand the following:

_____*(Initial)* I have a right to receive a copy of this authorization.
_____*(Initial)*I may withdraw or modify my consent to this release at any time.
_____*(Initial)* Any cancellation or modification of this authorize must be in writing.

This exchange expires on: _____ (*date*)

_____	_____	_____
Client Name	Signature of Client	Date
_____	_____	_____
Parent/Authorized Representative Name*	Signature of Parent/Authorized Representative	Date

*If signed by other that Client, please indicate the relationship between the Client and the Authorized Representative: _____