SWANSON PSYCHOLOGY, INC.

A Psychological Corporation

16311 Ventura Boulevard, Suite 925, Encino, California 91436

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby authorize Brian Swanson, Psy.D., J.D., licensed clinical psychologist, to release and/or receive confidential information to/from the individual or organization identified below:

_____

Name of Individual or Organization

_____

Street Address

_____

City, State, and Zip Code

_____

Telephone Number

I understand that this authorization may be revoked at any time by submitting a written request to Swanson Psychology, Inc. This authorization will automatically expire one year from the date of signature or upon termination of treatment, whichever occurs first. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

_____

Client's Name (Printed)

_____ _____

Client's Signature *Date*

_____ _____

Legal Guardian's Signature (if client is a minor) *Date*