Sonal Dhillon, M.A., LMFT #85497

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Authorization for Release of Information

Client Name(s):____

Date(s) of Birth: ____

This statement authorizes Sonal Dhillon to release and/or exchange information with the following individuals and/or organizations:

Name: Phone:	Client Initial
Name: Phone:	Client Initial
Name: Phone:	Client Initial

This information may consist of the following:

- Summary information regarding therapy experience including clinical opinions, assessments, and histories.
- Summary consultation information from ecclesiastical leaders or previous counselors.
- Other: ____________________________

This information will be used for the following purpose(s):

- Further mental health evaluation and treatment.
- Other: _____________________________

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

- ❑ Do not release.

I understand that I may revoke this authorization by writing at any time and that this release will be good from one year after the date of signing unless otherwise specified in writing. I (we) have read the foregoing with respect to the sharing of this personal information between the mentioned parties and agree to these conditions.

Signed (Client or Guardian)

Signed (Client or Guardian)

Therapist

Date

This is a strictly confidential client medical record. Redisclosure or transfer is expressly prohibited by law.