

# Mental Fitness Lifestyle, Inc.

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## AUTHORIZATION TO RELEASE INFORMATION

Client: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize **Allison Carter, Psy.D.** (Licensed Psychologist PSY19493 ) and Mental Fitness Lifestyle, Inc. to disclose to and/or receive from:

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

information pertaining to my/my child's psychological services rendered from:

\_\_\_\_\_ to \_\_\_\_\_.

Specific information requested includes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_.

This authorization is good through \_\_\_\_\_ or until I revoke its authorization.  
(fill in date) (circle this option)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_