

**CLIENT CONSENT
&
DISCLOSURE OF INFORMATION**

I, _____ hereby
(Client, Parent or Guardian)

authorize Analia Castanos-Davis to disclose to

(Name of Person, Government or Medical Agency)

(Address and Telephone Number)

the following specific information:

I am aware of and expect that all information is confidential and is protected by the policies of Analia Castanos-Davis, M.A., the agency requesting and receiving the above information, and by State and Federal regulations.

Date Client/Parent or Guardian

Signature

Client Signature

Client Signature

Send Original with Request
Copy in client record