Joshua Cross

California State Marriage and Family Therapist License MFT 46629
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Consent to Release Health Records

Client's Name:

_____ DOB ____/___/_____

_____ DOB ____/___/_____

_____ DOB ____/___/_____

I hereby give permission to release the following information between individuals or agencies listed below and **Joshua Cross, MFT.**

Regarding: ___Education ___Psychiatric ___Medical ___Social ___Psychological ___Psychometric testing

I also understand that this information may not be released to any person or organization other than those stated above or below without my written permission. A photocopy of this authorization shall be considered valid.

I understand that this Consent is subject to revocation by me at any time except to the extent that action has been taken in reliance therein.

Health Care Provider Phone Address City Zip

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_____

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_____

_____ _____ _____
Signature of Client Date Printed Name

_____ _____ _____
Signature of Client Date Printed Name

_____ _____ _____
Signature of Client or Parent/Guardian Date Printed Name

Day____Month_____Year_____
Expiration Date of Consent to Release Information