

**Lifespan Development Center**  
Consulting and Clinical Psychology

1101 Eugenia Pl, Suite D  
Carpinteria, CA 93013

Phone: 805-566-0441  
Fax: 805-566-0051

**Authorization to Release Information**

Federal law requires your specific authorization for the release to appropriate parties any information about you or your child's treatment for certain conditions. Please complete all information below.

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Date of Birth

I, \_\_\_\_\_, authorize the exchange information between

**ROLAND ROTZ, PhD (PSY12424)** and the following party:

\_\_\_\_\_  
Name

\_\_\_\_\_  
contact info

The information is required for diagnostic assessment, treatment planning and coordination of services.

Information to be obtained or released:

- Assessment    Diagnosis    Psychological Evaluation    Treatment Plan or Summary  
 Presence/Participation in Treatment    Progress in Treatment    Educational Information  
 Medication Management Information    Other: \_\_\_\_\_

I know that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client/ guardian

\_\_\_\_\_  
Signature of client/guardian

*This consent is subject to revocation at any time and will expire automatically upon termination, within one year of signature date, or by the date specified: \_\_\_\_\_*