RELEASE OF CONFIDENTIAL INFORMATION

TO: _____

I authorize my therapist, _____, at

Flourish Counseling Center
41911 5th St. #200
Temecula, CA 92590
(951) 249-3628

my permission to:

- ☐ Release
- ☐ Receive

medical, psychological, or educational information concerning:

Name of Client: _____

Expiration:

- ☐ Six months after date below
- ☐ One year after date below

I understand that, upon my request, I may receive a copy of this release. I further understand the above consents can be withdrawn by me, in writing, at any time and that the information which is being disclosed is from records whose confidentiality is protected by law.

Client/Parent Signature_____Date_____

But I am like an olive tree flourishing in the house of God; I trust in God's unfailing love for ever and ever. ~Psalm 52:8