

**Consent to Release Information by Patient Pursuant to the Confidentiality of Medical Information Act**

By signing this document, I, \_\_\_\_\_  
hereby authorize Cynthia Lechuga Robles, MFT (Lic # MFC 24511) to disclose my  
information and records obtained in the course of assessment, diagnosis and/or treatment to

\_\_\_\_\_  
Name and functions of the person to whom disclosure is made including address and telephone number

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This disclosure of information and records authorized herein is required for assessment, diagnosis and treatment purposes.

The specific uses and limitations on the types of medical information to be disclosed are as following:

\_\_\_\_\_  
\_\_\_\_\_  
Such disclosures shall be limited to the following specific types of information:

\_\_\_\_\_  
\_\_\_\_\_  
This authorization shall remain valid for one year following the date signed below.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient