

**Consent to Release Information of Minor Patient by
Parent/Guardian Pursuant to the Confidentiality of Medical
Information Act**

By signing this document, I, _____
Parent/guardian of _____,
(DOB _____), hereby authorize Cynthia Robles, MFT to disclose
the above named minor's information and records obtained in the course of
the minor's assessment, diagnosis and/or treatment to:

Name and profession 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 Parent/Guardian

_____ Date _____

Signature of Parent/Guardian

_____ Date _____

Signature of Minor

_____ Date _____