# *TEMENOS Center for Integrative Psychotherapy*

## AUTHORIZATION FOR RELEASE OF INFORMATION

**CLIENT NAME _____ Date of Birth _____**

With my signature below, I give my authorization for ***Temenos Center for Integrative Psychotherapy*** to discuss/exchange information relevant to my treatment with the below-named person for the purpose of psychotherapeutic assessment, planning and treatment.

Psychotherapist/Psychiatrist/Physician/Agency: _____

_____

Address: _____

Phone Number: _____

_____ Psychotherapeutic/psychiatric diagnostic and treatment information
_____ Psychological reports & testing results
_____ Medical and diagnostic reports/information
_____ Other _____

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _____ do not release.

This information will be kept strictly confidential. This authorization is valid from the date of authorization until the client revokes it or upon completion of treatment.

_____ _____
**Client Signature** **Date**

_____ _____
**Temenos Clinician Signature** **Date**

**Temenos Center for Integrative Psychotherapy**
**1 Bodega Avenue, Suite 4, Petaluma, CA 94952**
**707-992-5015**