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EXCHANGE OF INFORMATION CONSENT

I hereby give my permission for a mutual exchange of information between

Dr. Seima Diaz, Ed.D., LMFT and:

_____

from the medical and/or psychological records of:

_____ _____
Patient Name *Date of Birth*

for the purpose(s) of _____

_____

This release is valid until _____

Information requested:

- ❑ Psychological Testing
- ❑ Psychological Treatment
- ❑ Educational Testing
- ❑ Academic Progress
- ❑ Medical Reports
- ❑ Initial Evaluation
- ❑ Summary of Treatment

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Responsible Party *Relationship*