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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*