

DIANE SANTAS, PH.D.
CLINICAL PSYCHOLOGIST
5625 COLLEGE AVENUE, SUITE 212
OAKLAND, CALIFORNIA 94618
(510) 834-4848

ORI ELIS, PH.D.
PSYCHOLOGICAL ASSISTANT
5625 COLLEGE AVENUE, SUITE 212
OAKLAND, CALIFORNIA 94618
(510) 854-0415

Consent to Obtain/Release Confidential Information

Client Name: _____

Date of Birth: _____

I hereby request and authorize Ori Elis, Ph.D. and:

Name: _____

Relationship: _____

(If teacher) Subject: _____

Phone: _____ Email: _____

Name: _____

Relationship: _____

(If teacher) Subject: _____

Phone: _____ Email: _____

Name: _____

Relationship: _____

(If teacher) Subject: _____

Phone: _____ Email: _____

to exchange information concerning: _____
(client name)

This includes the release of the following types of records:

Medical _____ Academic _____ Legal _____ Psychological _____

I understand that this is to be held strictly confidential and cannot be released again without my written consent. This consent is effective from _____ until treatment end or until _____.
(Date)

(Parent/ Guardian)

(Date)