COMPREHENSIVE FAMILY COUNSELING, INC.
9485 SW 72nd STREET
SUITE A-242
MIAMI, FLORIDA, 33173
Tele. 305.305.5819 - Email: Discoveryourself25@gmail.com

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Date: ____________

Client's name: ____________________________ Date of Birth _________ MR#____________

I hereby authorize the mutual exchange of records/communication pertaining to my child or myself, __________________________, between Maria Rodriguez, LMFT and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, guardian ad litem, courts, other psychotherapist, immigration, attorneys, etc.:

Name	Address & Telephone #

The purpose for making these records available is: to facilitate communication and collaboration between the therapist and outside care to ensure the well-being of the client.

I certify that I am the parent or legal guardian of the child named above or that I am a client of majority age and have the authority to sign this release.

______________________________ ____________________________________
Name (print) Signature

______________________________ ____________________________________
Name (print) Signature