Authorization to Use, Disclose, Receive, or Exchange Information

Client Identification Information:

Name:_______________________________ Date of Birth:______________

This information is to be disclosed to and/or exchanged with:

Melissa Procker Sorci, Ph.D.
Licensed Psychologist PSY 23816
51 East Campbell Ave., Suite 170
Campbell CA 95008
(408) 782-9538 Voice (408) 370-6196 Fax
mpsorciphd@gmail.com; www.melissasorci.com

I authorize:____
Name of individual(s), school, professional, agency, or attorney

____
Address, City, State, Zip code

_____________________________ _________________________________
Fax Number Phone Number

____
Email address

To use, disclose, exchange, or receive the following information:

□ Academic records □ Psychological Assessment
□ Telephone Consultation □ School Records / Contact with School Personnel
□ Email/Digital Communication □Other:_______________________________

Dates to be released: □ All dates □ From _____________ to _______________

____
Signature of Client/Guardian

____
Date (This authorization is valid for 12 months)

____
Relationship to Client □ Client is a minor child