PEREZ MOON PEREZ
PSYCHOTHERAPY & FAMILY COURT SERVICES

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Authorization for Release of Confidential Information

❖ **If this does not apply to you, please mark N/A, then sign on signature line**

NAME:_____ **DOB:**_____
NAME:_____ **DOB:**_____
NAME:_____ **DOB:**_____
NAME:_____ **DOB:**_____

Disclosure of the specific type of information which is considered instrumental in the ongoing evaluation and treatment of the above individual shall be limited to the following professional:
I hereby authorize:

- ☐ **Claudia S. Moon-Perez, LMFT 31370**
- ☐ **Robert R. Perez, LMFT 28017**
- ☐ **Jennifer M. Simmons, LMFT 34926**
- ☐ **Katherine Hall, AMFT 109169**
- ☐ **Ashley Saldana, LCSW 101444**
- ☐ **Catherine Perez, BA 0931500**

Professional Supervised Visit Monitor

Disclose and release information to party indicated below: (please provide name and contact info)
1._____
2._____
3._____
4._____
5._____

I understand that I may revoke this consent at any time, except to the extent that has already been acted upon prior to my revocation. This consent shall remain in effect unless a written request for revocation is received.
I am fully aware that before my records may be released, I must give consent. I may refuse to sign this release and having been made aware of State and Federal statutes, I voluntarily and knowingly sign.

_____
Signature

_____
Date