Lisa Montalvo, MFT, CEAP, SAP
1395 San Carlos Avenue, Suite C#4
San Carlos, California 94070
(650) 631-0909
www.BayAreaCounselingService.com

Authorization to Exchange Information

I, ____________________________ hereby authorize and request that Lisa Montalvo,
(Client)
MFT, CEAP, SAP may release all confidential, professional information pertaining to me

or my minor children for the purpose of treatment planning and coordination to:

____

General summary of client history and the following specific information:

____

____

____

I understand that I may revoke this consent at any time by informing the above parties in writing. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature _________________________ Date ______________________
(Client)

Signature _________________________ Date ______________________
(Parent or Guardian)