Educational Awakening Center

RELEASE OF RECORDS

(PLEASE PRINT)

I, _____,

the undersigned, hereby authorize and direct my therapist:

Therapist Name: _____

Telephone: (_____) _____

to release all personal information pertaining my evaluation and treatment to:

Educational Awakening Center
5850 Canoga Ave. Suite 400
Woodland Hills, CA 91367

x _____

Patient Signature Date