



5050 El Camino Real  
Suite 101  
Los Altos, CA 94022  
Phone: 650-937-1111  
Fax: 650-937-0011

3685 Mt. Diablo Blvd.  
Suite 203  
Lafayette, CA 94549  
Phone: 925-283-9100  
Fax: 925-283-9104

12625 High Bluff Dr.  
Suite 202  
San Diego, CA 92130  
Phone: 858-259-8281  
Fax: 310-806-9640

11500 W. Olympic Blvd.  
Suite 430  
Los Angeles, CA 90064  
Phone: 310-806-9655  
Fax: 310-806-9640

2274 South 1300 East  
#G15-114  
Salt Lake City, UT 84106  
Phone: 801-364-1680  
Fax: 801-532-3753

**AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION**

This form, when completed and signed by you, a client of BODIN or his/her legal representative, authorizes Bodin Associates, and/or its clinical and administrative staff, to release information from your record to the person(s) you designate, request release of such information from the person(s), or exchange information with person(s) you designate, pursuant to the conditions specified below, and in accordance with governing statutes and regulations.

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Is currently utilizing the consultation and/or psychological testing evaluation services of BODIN.

**In addition to verbal exchange, the records covered by this authorization include:**

<input type="checkbox"/> Transcripts/Grade Reports	<input type="checkbox"/> Psychological Assessment/Reports
<input type="checkbox"/> School Counseling Records	<input type="checkbox"/> Treatment Records (including medical, mental health and substance abuse)
<input type="checkbox"/> Court Documents; Attorney's Records	<input type="checkbox"/> Other: _____

**I give my permission for the information named above to be:**

- Exchanged between BODIN and the party named below
- Released to BODIN from the party named below
- Released from BODIN to the party named below

**Records to be exchanged with:**

Name or function of person(s): \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

**OR**

- Released from BODIN to specific schools and programs from the Bodin Master List of Programs. (Such list shall be provided to client upon clients' written request)

**I am authorizing BODIN to release, request or exchange this information as specified for the following purpose(s):**

- Educational placement
- Psychological evaluation
- At request of individuals
- Other: \_\_\_\_\_

**This authorization is subject to the following conditions:**

This authorization shall remain in effect until \_\_\_\_\_ or one year.

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to BODIN's office address. However, my revocation or modification will not be effective until BODIN receives it.

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship of Authorizing Party to Minor

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship of Authorizing Party to Minor