

**Otis College of Art and Design
Student Counseling Services**

REQUEST TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____

This gives Student Counseling Services and

Name: _____

Address: _____

Phone: _____

permission to mutually release information. The disclosure of information authorized herein is required for the following purpose: facilitation and coordination of on-going therapy and health care.

The following specific types of information are required: diagnosis, prognosis, medications, assessments, course of treatment and response.

Signature: _____ Date: _____

THIS FORM SHALL BE VALID FOR ONE YEAR FROM THE DATE SIGNED
UNLESS OTHERWISE SPECIFIED.

Otis College of Art and Design
Student Counseling Services
9045 Lincoln Blvd
Los Angeles, CA 90045
Phone: (310) 846-2639