AUTHORIZATION TO DISCLOSE INFORMATION

_____ _____ _____
(Name of Patient) (Date of Birth) (Date)

I, _____ hereby authorize

James E. Walton, Ph.D. at 6306 Babcock Ave., Suite 2, Valley Glen, CA 91606 to release all information and exchange all information regarding the psychological, physical, and/or educational background of the above-named patient to

_____
(name of physician, therapist, hospital or other)

_____
(address)

_____
(telephone)

I understand that I have a right to receive a copy of this authorization if I so request.

_____ _____
(signature) (address)

_____ _____
(relationship to patient)

_____
(telephone)

Dr. James E. Walton, Ph.D.
Support, Safety, Solutions