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PARENTAL RELEASE OF INFORMATION for PHYSICIANS, DENTISTS, PSYCHOTHERAPISTS AND/OR OTHER PROFESSIONALS

I,_____authorize all therapists, physicians, medical staff and other professionals who have provided service to us or our child(ren) to exchange any and all information regarding our child(ren) with Mitchell Rosen, LMFT. We authorize the release of any information requested by Mitchell Rosen, including (but not limited to) our own or our children's medical records, treatment or diagnostic information, or any other information to assist in the completion of a Court-ordered child custody or psychological evaluation. The foregoing authority shall continue in force until revoked by one or both of us in writing. A faxed or photocopy of this release shall be considered as an original.

_____ _____ Name of Parent date:

_____ Signature of Parent

Health Professionals: Please send a letter, fax or email summarizing your experience with this family. As a child custody evaluator appointed by the Family Law Court, I am especially interested in your observation of the child's functioning socially and academically as well as any interaction with parent(s), step-parent(s), significant others or family members. If you have significant knowledge, you may call me at: 951-541-3158, however please send this form first and let me know times you are available to speak telephonically.

Please do not allow either parent to review this form and be aware information provided in NOT CONFIDENTIAL. Some or all of the information you provide may appear in my final report. While most child custody cases settle, the parties have a right to subpoena evaluator's records and review its contents. Under unusual situations, a collateral may be contacted by a party's attorney or appear in court. IF YOU CAN VERIFY INFORMATION PROVIDED WOULD BE DETRIMENTAL TO YOUR PATIENT IF RELEASED YOU MAY ASK THE EVALUATOR TO KEEP IT CONFIDENTIAL.

Thank you,

Mitchell H. Rosen Website: mrosenmft.com