Authorization to Release Confidential Information

I (name of client) _____ hereby authorize

(name and phone number of LMFT) _____

To release confidential information obtained during the course of treatment to (name, phone number, and function of the person or entities to which information is to be released) _____

_____

This authorization permits the release of the following information:

_____ Any and all information necessary for coordination of care

_____ Diagnosis _____ Treatment Plan

_____ Test Results _____ Dates of Treatment

_____ Summary of Treatment _____ Progress _____ Other

_____

for the purposes of assessment and/or treatment planning.

The above information may be released verbally or in writing. This authorization is given of my own free will and is in effect for one year from the date bellow. I understand that any revocation or modification of this authorization must be in writing. I may request a copy of this release.

_____ _____

name and signature of client or client's representative Date