Authorization For Release/Exchange of Confidential Information

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Is Hereby Authorized to:

__Obtain from __Release/ Exchange

Regarding:

__My treatment __My child's treatment

Name/Organization:_____

Address/Phone:_____

This Authorization permits the exchange or release of the following information:

___Summary of Assessment ___Treatment Plan
___Diagnosis ___Progress to Date
___Summary of Treatment ___Copy of Records
___Other_____

The recipient may use the information described above solely for the following purpose(s):

_____

I may revoke this authorization in writing at any time. I understand that I cannot do anything about information already disclosed under this authorization. I hereby release Andra Coulter, MFT from all legal responsibilities or liability that may arise from disclosure of records of information in reliance on this authorization. A facsimile or photocopy of this authorization may be accepted in lieu of the original. I understand this authorization will expire on the date stated here:_____or automatically expire one year from the date of my signature.

_____ _____
Client's Name Parent/Guardian Name(s)

_____ _____
Client Signature Parent/Guardian's Signature

_____ _____
Date Date

_____
Parent/Guardian Name(s)

_____
Parent/Guardian's Signature

_____
Date