Martha Simpson, LMFT, CSAT, CPTT
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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I (Client)_____ authorize Martha Simpson, LMFT
to ☐Obtain from ☐Exchange with ☐Release to

(Name of 3rd party)_____ (Ph #)_____

confidential information obtained during the course of my treatment. This authorization permits the release of the following:

☐ Any and all necessary information (IF YOU CHECK THIS BOX YOU NEED NOT CHECK OTHER BOXES)
- ☐ Treatment plan/summary
- ☐ History/intake
- ☐ Diagnosis/Prognosis
- ☐ Psychological/Clinical test results
- ☐ Psychiatric evaluation/medication history
- ☐ Dates of treatment
- ☐ Other (specify)_____

The release of the information described above is for the purpose of:
☐ Evaluation/assessment and/or coordinating and improving treatment
☐ Other (specify)_____.

The specific uses and limitations on the types of information to be released are as follows: _____.

I understand I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

This consent will automatically expire one year after termination of therapy with Martha "Marty" Simpson, LMFT or alternatively on the following date, condition, or event described here: _____.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Signature	Printed Name	Date