**Authorization for Release of Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Mary Lee Schrader, MA, LAMFT with *The Therapy Shop*to exchange the following information about me:

*Check Where Applicable*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Diagnostic Assessment |  |  | Progress Notes |
|  | Intake Summary |  |  | Other, as specified |
|  |  |  |  | |

With the following agency or individual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the following purposes:

*Check Where Applicable*

|  |  |
| --- | --- |
|  | Planning and/or continuing treatment |
|  | Exchanging information |
|  | Court, probation, parole requirement |
|  | Other, as specified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I understand the information will not be disclosed to other sources unless specifically authorized by law, or by my written consent. I understand I may refuse to release this information and the consequences of this refusal have been explained to me.

I understand I may revoke this consent at any time (not retroactively) and that this revocation must be in writing. This consent will automatically expire one year from the date of my signature, unless otherwise noted.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_