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

I _____/_____ [Client(s)] authorize Martha Simpson, LMFT to

☐Obtain from, ☐Exchange with, ☐Release to _____[Name of Provider or 3rd party] 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) _____

I authorize the release of the information described above 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:

_____
_____

The specific uses and limitations on the use of the information 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 Simpson, or alternatively on the following date, condition, or event described here: _____
_____.

Signed by: _____/_____ Date: _____

[Client(s) or Clients' Representative]

Printed Names: _____/_____