Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individual providers regarding your treatment (e.g. previous treating therapist, current health care providers, parents or school)

Client Name(s): _____

Client Date of Birth: _____

Release of information from Vanessa Fierstadt LMFT to Another Person or Party Listed Below

I authorize my Therapist to release/exchange the following information to:

Name: _____

Number: _____

Address: _____

Information to be released:

(Please Check)

_____ Screening Information _____ Behavioral and Psychological Reports

_____ Treatment Plan _____ Counseling Notes

_____ Coordination of Care _____ Intake and History

_____ Other: _____

This release with be valid until the termination of treatment or authorization from client to revoke

Expiration date: _____

This authorization may be revoked at any time.

Name of Patient, Client or Authorized person (print):

_____

Signature of Patient, Client or Authorized person:

_____ Date: _____