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Authorization to Release/Exchange Confidential Information

I,____authorize Marci Danielson, M.S., LAMFT to:

_____ release to:
_____ obtain from:
_____ exchange with:

Name ____

Address ____

Phone _______________________

the following information pertaining to myself:
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ dates of treatment attendance
_____ other (specify) ______________________________

for the purpose of:
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) ______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on

the following earlier date, condition, or event

____
DATE

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Social Security #:__________________ OR Date of Birth:_____________________

____
Signature of Client Date

____
Signature of Witness Date