

Coral Compagnoni, LMFT

Licensed Marriage and Family Therapist #84799

1061 El Monte Avenue, Suite B, Mountain View, CA 94040 / (650) 503-3334

CONSENT FOR THE RELEASE OF INFORMATION AND RECORDS

Information is to be released:

 One way, from Person No. 1 to Person/Organization No. 2

 Two way, between both Person No. 1 and Person/Organization No. 2

No. 1 Person: _____ Phone: _____

to disclose records and information regarding:

Client's Name

D.O.B. _____

To No. 2 Person or Position: _____ Phone: _____

Agency:

Address:

These records are protected by the California Welfare and Institution Code, Section 5328. Disclosure shall be limited to the following information:

Medical Mental Health Education Social History/Assessment Financial

Other (specify): _____

The purpose of this information is for: _____

This authorization shall become effective on _____ (date of signature). I understand that my authorization will remain effective from the date of my signature until _____ (not to exceed 90 days from date of authorization for one time release, or 12 months or as required by court or law for ongoing provision of services), and that the information will be handled confidentially in compliance with all applicable federal laws.

I have read and understand the nature of this release.

I consent to the release of information and records.

I understand that I may revoke the authorization at any time by written, dated communication.

I understand that I have the right to receive a copy of this authorization if I so request.

(Client Name)

(Client Signature)

(Date)

Consent Revoked:

(Client Name)

(Client Signature)

(Date)