**Mary Phalon, M.S., MFT**

**Licensed Marriage and Family Therapist**

 **(925) 322-9305**

**Authorization to Release/Exchange Confidential Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize Mary Phalon, MFT, to Release and/or Exchange confidential information obtained during the course of my treatment with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name or function of the person(s) or entities to whom information is to be released/exchanged)

This Authorization permits the release and/or exchange of the following information: \_\_\_\_ Diagnosis \_\_\_\_ Treatment Plan \_\_\_\_ Progress to Date \_\_\_\_ Prognosis \_\_\_\_ Clinical Test Results \_\_\_\_ Dates of Treatment \_\_\_\_ Any and All Information Necessary

\_\_\_\_ Other (specify)

I authorize the release and/or exchange of the information described above for

the following purpose(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: \_\_\_\_\_\_\_\_\_\_\_\_\_ or one year from today’s date. (expiration date).

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client or Parent/Guardian if under the age of 18)

\*If signed by other than Patient, please indicate the relationship between Client and his/her Representative.