

*Tina Dahlenburg, M.S., Licensed Marriage & Family Therapist  
15300 Ventura Blvd. Suite 201, Sherman Oaks, Ca 91403  
818-970-7751*

### **Authorization to Release Confidential Information**

I, [Name of Patient] \_\_\_\_\_ (“Patient”) hereby authorize [Name of Provider] (“Provider”) \_\_\_\_\_ to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] \_\_\_\_\_ (“Recipient”).

This Authorization permits the release 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 of the information described above for the following purpose(s):

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 by Recipient are as follows:

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

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.

**This authorization shall remain valid for one year or until the termination of services, whichever comes first.**

Signature of Client/ Guardian: \_\_\_\_\_

Date: \_\_\_\_\_