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RELEASE OF INFORMATION

I, [Name of Patient] _____ hereby authorize Judi Mackey, MA, LMFT 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]:

_____ . This Authorization permits the release of the following information (Check all appropriate):

Diagnosis Treatment Plan _____ Progress to Date _____ Prognosis ____
Dates of Treatment Any and All ____ Written communication ____
Information Necessary Other (specify) _____

_____

I authorize the release 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: ("Expiration Date") _____

_____
Client Name (Please Print)

_____
Signature of Client

_____
Date