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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, ____, do hereby give permission to Rennie M. Smith, MA, MFT, Licensed Marriage & Family Therapist (MFC#50238) to release information to and to receive information from the following:

Name: ______________________________ Organization: ________________________

Street Address: ____

City & State: _________________________ Zip Code: ___________________________

Phone Number: ______________________ Fax Number: ________________________

I understand that this exchange of information will only pertain to my treatment. I also understand that this Authorization will be considered void immediately upon my request in writing, one year after the date I have signed it or at which time treatment is terminated (whichever shall occur first).

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This disclosure of information and records authorized herein is required for the following purpose:

- ☐ assessment and diagnosis
- ☐ medical compliance
- ☐ referral
- ☐ treatment coordination
- ☐ medication evaluation
- ☐ recommendations

The specific uses & limitations on the types of medical information to be disclosed are as follows:

- ☐ medications
- ☐ assessment and diagnosis
- ☐ recommendations & progress
- ☐ testing results
- ☐ coordination of treatment

____ ____________________
CLIENT'S NAME PRINTED *Date of Birth*

____ ____________________
CLIENT'S SIGNATURE *Date*

____ ____________________
PARENT SIGNATURE (if client is a minor) *Date*