

Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individual providers regarding your treatment (e.g., previous treating therapist, current health care providers, parents, or school).

Client Name(s): _____

Client Date of Birth: _____

Release of information from TEJE ALIBERTI, LMFT to Another Person or Party Listed Below I authorize my therapist to release/exchange the following information to:

Name: _____

Number: _____

Address: _____

Information to be released (please check):

- Screening Information Counseling Notes Coordination of Care
- Treatment Plan Intake + History Behavioral + Psychological Reports
- Other: _____

This release will be valid until the termination of treatment or authorization from client to revoke:

Expiration Date: _____

This authorization may be revoked at any time.

Name of Patient, Client or Authorized person (print)

Signature of Patient, Client or Authorized person

Date