



## Authorization to Release Confidential Information

I, [Name of Client/Guardian] \_\_\_\_\_ hereby authorize Jon B. Pease, MA, LMFT to release confidential information obtained for myself child family (circle one) 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:

Any/All Information       Diagnosis       Treatment Plan  
Necessary  
 Progress to Date       Prognosis       Clinical Test Results  
 Dates of Treatment       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.

The Authorization shall remain valid until: \_\_\_\_\_ (“Expiration Date”)

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Client’s Representative)

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Client’s Representative)