Authorization to Release Confidential Information

I hereby request and authorize _____
doctor, therapist, school, agency, etc.

_____
Street address City State Zip

and Molly LaCroix, LMFT to exchange the following information:

_____ Any and all information necessary for coordination/continuity of care

_____ Diagnosis _____ Treatment Plan _____ Prognosis

_____ Progress To-Date _____ Clinical Test Results _____ Client Records

_____ Dates of Treatment _____ Summary of Treatment

I understand I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid for _____ **Six Months** _____ **Twelve Months**

_____ _____
Client Name (Print) Date of Birth

_____ _____
Signature Date Signed

_____ _____
Client Name (Print) Date of Birth

_____ _____
Signature Date Signed

Relationship to client if signed by individual other than client: _____

Molly LaCroix, LMFT
Licensed Marriage & Family Therapist

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