

Eva Tak, MFT

Changing Perspectives

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Authorization to Release Confidential Information

I, [Name of Client] _____ hereby authorize
Eva Tak, MFT to release confidential information obtained during the course of my treatment to
[Name of person or entity to whom information is to be released]

_____ (Recipient).

This authorization permits the release of the following information:

- Diagnosis Treatment Plan Progress to Date
 Prognosis Clinical Test Results Dates of Treatment
 Any and All Information Necessary
 Other (specify) _____

I authorize the release of the information described above for the following purpose:

The specific uses and limitations on the type 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: _____
(Client or Client Representative Signature)

Date: _____

Print Name: _____