RENÉE DIVINE LMFT

Relationship & Sex Therapist

Authorization for Release of Confidential Information

In consideration for furnishing the designated information to the person or organization named below, I hereby release and agree to indemnify Renee Divine, MA, LMFT from all liability, damages, and costs arising from the acts or omissions of other person or organization.

I,_____ _____and,
Print Name Date of Birth

I,_____ _____
Print Name Date of Birth

Authorize Renee Divine, MA, LMFT to:

_____Disclose information to
_____Obtain information from
_____Exchange information with _____
Name of Person or Agency

_____
Address, Phone and Fax Number

Regarding _____myself
_____my son/daughter, _____ _____
Name Date of Birth

Information to be disclosed is:

_____Discharge/Treatment Summary
_____Progress Notes
_____Academic Records
_____Psychological Testing and Reports
_____Diagnostic Impressions
_____Chemical Dependency Evaluation
_____Medical History
_____Other_____

The purpose of this disclosure is_____

I understand that I may revoke this consent at any time by written notice. Without an expressed revocation (unless information has been released) it will expire after 12 months from the date of my signature. I also understand that Renee Divine, MA, LMFT only releases records created by her personally.

_____
Signature of Client, Parent or Guardian Date

_____
Signature of Client, Parent or Guardian Date

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