Paola Caraker MFT

License # 45183

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Authorization to Release Confidential Information

I, _____hereby authorize **Paola Caraker MFT**

to release confidential information obtained during the course of my treatment to:

_____
_____
_____

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(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: _____

_____ _____

Client or respresentatives's signature Date

_____

Client or representatives Print

Paola Caraker MFT

Date