CENTER FOR MINDFUL PSYCHOTHERAPY, INC.
Authorization to Release Confidential Information

I, [Name of Client] ________________________________________________

hereby authorize [Name of Provider] ______________________________________

(Associate Marriage and Family Therapist at the Center for Mindful Psychotherapy) 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: ____________________________ (‘Expiration Date’)

By: ____________________________________________     Date: __________________

   Client Signature