# 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