TERRI J. CLARKE
Marriage, Family, Child Therapist · Certified Imago Therapist · CLMFT, MFC 26011

Authorization to Release Confidential Information

I, (name of client) _____, hereby authorize (name of provider) _____ to release confidential information obtained during the course of my treatment to Terri J. Clarke, LMFT.

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: _____

By: (Patient or Patient's Representative) _____

Date: _____