

ERIKA DEMERS, M.A.
Licensed Marriage Family Therapist #44463
1433 11th St. Unit F, Arcata CA 95521 (707) 496-4629

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize Erika Demers, LMFT and

_____ **Name** of physician, attorney
_____ agency, hospital, school
_____ psychotherapist, etc.
_____ **Address**
_____ **Phone number**

to exchange/request or provide confidential information verbally and/or in writing about myself___ or my child _____ for purposes of evaluation and treatment.

Such disclosure shall be limited to the following:

_____ Any and All Necessary Information	_____ Treatment Plan
_____ Summary of Treatment	_____ Prognosis
_____ Diagnosis	_____ medical information
_____ Dates of Treatment	_____ legal information
_____ Other:	

*This authorization will expire 30 days after the end of treatment, unless revoked in writing earlier or renewed. I understand that I may revoke this consent at any time, in writing, except to the extent that it has already been acted upon prior to my revocation.

_____	_____	_____
Client(s) name (print)	*Signature	Date

_____	_____	_____
Name of parent or legal rep	*Signature	Date