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**Authorization to Release Confidential Information**

I, \_\_\_\_\_, hereby authorize Rachel Finch Sulka to exchange confidential information obtained during the course of my treatment with \_\_\_\_\_  
\_\_\_\_\_. This

Authorization permits the release of the following information:

- Any and All Information Necessary
- Diagnosis
- Treatment Plan
- Prognosis
- Progress to Date
- Clinical Test Results
- Dates of Treatment
- Patient Records
- Summary of Treatment
- Other \_\_\_\_\_

I authorize the release of the information described above for the following purpose(s):  
\_\_\_\_\_. The recipient may use the information described above solely for the following purposes(s):  
\_\_\_\_\_

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This Authorization shall remain valid until: \_\_\_\_\_.

By: \_\_\_\_\_ Date: \_\_\_\_\_