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Consent to Release or Receive Confidential Information

I, _____, authorize Jennifer E. Harris, LMFT, RECEIVE information from

_____.

I, _____, authorize Jennifer E. Harris, LMFT to RELEASE information to

_____.

The nature of the information to be released and/or received is:

☑ Share/collaborate on appropriate information in my best interest

I understand that this consent will automatically expire 90 days from the date of signature and that I may revoke this consent in writing at any time. I further acknowledge that the information to be released and/or received was fully explained to me and this consent was given of my free will.

_____ _____
Client/Guardian Signature Date

*Please return a signed copy to me and your other practitioner via email.