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**Consent to Release or Receive Confidential Information**

I, (your name), authorize Jennifer E. Harris, LMFT, RECEIVE information from

(name of provider or professional).

I, (your name), authorize Jennifer E. Harris, LMFT to RELEASE information to

(name of provider or professional).

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.