Briana Messerschmidt, M.S.
Registered Associate Marriage and Family Therapist #AMFT 91883
Supervised by Dr. Mary M. Read Ph.D., LMFT # 25112
5212 Katella Ave. Ste 103-B
Los Alamitos, CA 90720
562-344-5416

Authorization to Release and Disclose Confidential Information

I, _____ ,
(Client Name) (Date of Birth)

Authorize the release/exchange of information between:

Briana Messerschmidt, AMFT & APCC 562-344-5416
5212 Katella Ave. Ste 103-B, Los Alamitos, CA 90702 BrianaMessers@gmail.com

And:

_____
(Name) (Phone Number)

_____
(Mailing Address) (E-mail Address)

Clinical information to be released:

❒ Entire Record

Specific Information:

- ❒ Assessment/Evaluation
- ❒ Medication History/Current Medications
- ❒ Diagnosis
- ❒ Treatment Plan
- ❒ Other_____

Sensitive Information:

- ❒ Drug and Alcohol Treatment and History
- ❒ Medical Treatment and History
- ❒ HIV/AIDS/STI/STD History
- ❒ Abortion History
- ❒ Pregnancy and/or Birth Control Records

Purpose of Disclose, Release and/or obtain:

- ❒ Continuity of care by another professional or health care facility
- ❒ Client's request ❒ Other_____

This Authorization shall be terminated 1 year from the date of signature _____

NOTE TO CLIENT: You have the right to receive a copy of this form. You may revoke this authorization to release information at any time. However, information may have already been released on the basis of this authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____
Patient/Client Signature Date

_____
Parent/Guardian Signature (if client is a minor) Date

_____
Witness Signature with Title Date