Authorization for Release of Information
Rachel Ewing, LMFT (MA: 1864, CA: 94702)

Client's Name: _____ Date of Birth: _____

I request and authorize the exchange information of the client named above with:

Name:

Address:

City: _____ State: _____ Zip Code :_____

Phone: _____

This request and authorization applies to:

☐ —Healthcare information related to the following treatment, condition, or dates:

_____
_____
—

☐ Mental health information (diagnoses, treatment plan, progress)

☐ Emergency Contact Only

☐ Other:

_____
_____
_____
—

Client (or guardian) Signature: _____ Date:_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED UNLESS REVOKED IN WRITING