Tiffany C. Shanks, MA, LMFT
Licensed Marriage & Family Therapist #84490
www.tiffanyshankstherapy.com
21241 Ventura Blvd, Suite 182, Woodland Hills, CA 91364
(818) 493-9580
Email: tiffanyshankstherapy@gmail.com

Consent for Bilateral Release of Confidential Information

_____ _____
Client Name Client DOB

I, _____, authorize the two parties (#1 & #2) listed below to release to each other confidential information about me, including but not limited to:

☐ Historical information ☐ Attendance ☐ Participation ☐ Cooperation
☐ Recommendations ☐ Session topics ☐ Progress ☐ Current status
☐ Summary of treatment ☐ Other _____

The purpose of this release is:

☐ Obtain information only ☐ Progress reporting ☐ Case updates
☐ Other _____

These parties are:

1. Name: Tiffany C. Shanks, MA, LMFT
   Licensed Marriage Family Therapist #84490

2. Name:_____

Professional Designation:_____

Address:_____

Phone:_____ FAX:_____

This consent shall be valid from_____ to _____
I, the aforementioned, understand that I may revoke this release, in writing, at any time, except to the extent that it has already been acted upon.

A FAX or photocopy of this release is to be considered as valid as the original.

_____ _____ _____
(Date) (Signature of Client) (Client Printed Name)

Copy/FAX given to: ☐ Client ☐ Parent ☐ Guardian ☐ Other Party _____
☐ CSW ☐ Representative
☐ Original retained by therapist in client file

Please remember that a Release of Information is not needed in situations that involve mandatory reporting.