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# Authorization to Release Confidential Information

I, [Name of Patient or Patient's Guardian] _____ ("Patient")

hereby authorize Ari Labowitz, LMFT ("Provider") to release confidential information obtained during

the course of my treatment to _____, and for

_____ to release information to Ari Labowitz during the course of my treatment.

This Authorization permits the release of the following information:

Any and All Information Necessary

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until one year from the below date:

By: _____ Date: _____

(Patient or Patient's Guardian)