MONICA BUTTAFAVA M.S., LMHC
CHILD AND ADOLESCENT PSYCHOTHERAPY
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CONSENT TO RELEASE & REQUEST CONFIDENTIAL INFORMATION

Client:_____ D.O.B._____

I (client/guardian) _____ hereby authorize Monica Buttafava, M.S, LMHC to exchange confidential information regarding treatment with:

Contact Name & Relationship: _____

Address:_____

Phone, Fax, Email: _____

Information to be disclosed:

☐ Diagnosis ☐ Treatment Plan

☐ Assessment ☐ Other_____

Purpose of this disclosure: _____

_____

_____

This authorization is in effect from _____ to _____, not to last more than one year. I understand that I may cancel or modify this authorization in writing prior to the expiration date. I understand that I have a right to receive a copy of this authorization.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Conservator Signature Date

_____ _____
Therapist Signature Date