Daniel Acosta, M.A., AMFT
Registered Associate Marriage and Family Therapist
Registration No. 93817
Employed and Supervised by Clinical Psychologist Dr. Heather Coakley
License Number PSY20178

Authorization to Release Confidential Information

I, [Name of Patient] _____("Patient")
hereby authorize [Name of Provider] _____("Provider")
to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] _____
_____("Recipient").

This Authorization permits the release of the following information:
____ Diagnosis ____ Treatment Plan ____ Progress to Date
____ Prognosis ____ Clinical Test Results ____ Dates of Treatment
____ Any and All Information Necessary
____ Other (specify)

I authorize the release of the information described above for the following purpose(s):
_____

_____

The specific uses and limitations on the types of information to be released are as follows:
_____

_____

The specific uses and limitations on the use of the information by Recipient are as follows:
_____

_____

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: _____("Expiration Date")

By:_____ Date:_____

(Patient or Patient's Representative)