Consent for Bilateral Release of Confidential Information

Roya Dedeaux * Licensed Marriage and Family Therapist * LMFT#95302*
5212 Katella Ave. Suite 101 * Los Alamitos, CA 90720

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Client Name

I, ______________________________, authorize the parties listed below to release to each other confidential information about me, including but not limited to history, functioning, symptoms, diagnoses, treatment, prognoses,, etc., for the purpose of:

____

____

These parties are:

Name: ______________________	______________________
Professional Designation ______________________	Professional Designation ______________________
Address : ______________________ ______________________	Address ______________________ ______________________
Phone ______________________	Phone ______________________
Fax______________________	Fax ______________________

This consent shall be valid from ________ to __________. I 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 a valid as the original.

______________	______________	______________
Date	Signature of Client (parent or guardian, if client a minor)	Printed Name

Copy given to: ____Client ____Other Party ____Parent ____Guardian
____ Representative _X_Copy Kept by therapist