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RELEASE AND/OR EXCHANGE OF CONFIDENTIAL INFORMATION

Completion, and signing, of this document authorizes the release and/or exchange of my confidential information between the named individual(s) and/or agencies below.

Disclosure of information for: _____

I _____ authorize ***Narissa L. Harris, LMFT*** located at

_____ the following release and/or exchange of information:
(Street) (city) (state) (zip)

__ Disclose of Information to __ Receipt of Information from __ Exchange of information with

Name or Agency Name: _____ Phone #: _____

Address:
_____
(Street) (city) (state) (zip)

I authorize the following information pertaining to _____to be disclosed:

__ Assessment
__ Consultation
__ Summary of treatment
__ Diagnosis
__ Treatment Plan
__ Progress Notes
__ Medical History
__ Educational History
__ Psychological test results
__ Psychiatric evaluation/medication history
__ Substance Abuse History
__ Verbal Exchange of Information
__ One Time __ On Going
__ Other (specify)
_____

The purpose of this release and/or exchange of information is for:

__ Evaluation, assessment, and/or coordinating treatment efforts
__ Other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Authorizing Party Signature Date
(Parent or Legal Guardian Signature if applicable)

Relationship to Client:
__ Self __ Parent __ Legal Guardian __ Conservator __ Other: _____

_____ _____
Therapist Signature Date