



Authorization for Release of Confidential

Information

I, _____, Birthdate: _____,
(Client Name)

authorize _____ (therapist) from Relationship Insights Therapy & Coaching (main licensee holder: Jen Rives, MA, LMFT, license #2322) to release information from my records for the following purpose(s):

- Disclose information to
- Obtain information from
- Exchange information with
- Other _____

to the following people and/or agencies:

1. _____
(Name of Person or Agency) (Address, Phone, Fax Number)
2. _____
(Name of Person or Agency) (Address, Phone, Fax Number)
3. _____
(Name of Person or Agency) (Address, Phone, Fax Number)
4. _____
(Name of Person or Agency) (Address, Phone, Fax Number)
5. _____
(Name of Person or Agency) (Address, Phone, Fax Number)
6. _____
(Name of Person or Agency) (Address, Phone, Fax Number)
7. _____
(Name of Person or Agency) (Address, Phone, Fax Number)

The purpose(s) of this disclosure is _____

This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 12 months, except to the extent that action based on this consent has been taken. This consent will expire automatically after 12 months from the date in which it was signed.

(Client, Parent or Guardian Signature)

(Date Signed)