Release of Confidential Information Authorization Form

Valentino Therapy, 3030 Bridgeway, Suite 108, Sausalito, CA 94965
Sharon Valentino, LMFT #51746

I,_____, Client - Phone: _____
Cell:_____, Email: _____
Address:_____ Fax: _____
Authorize the below parties to communicate.
I authorize Sharon Valentino, Licensed Marriage and Family Therapist MFC 51746, 3030 Bridgeway, Suite 108, Sausalito, CA 94965, phone 415.215.5363, fax 415.888.2990, e: sharon@valentinotherapy.com, to disclose the below noted information to:
1. I authorize (name)_____ (phone) _____
(fax) _____ (e-mail) _____
(address) _____
2.I authorize (name)_____ (phone) _____
(fax) _____ (e-mail) _____
(address) _____
3.I authorize (name)_____ (phone)_____
(fax) _____ (e-mail) _____
(address) _____

<u>To discuss and disclose to each other</u>, the below noted information:
Authorization is to disclose the following information (medical, psychosocial, substance abuse, and psychiatric or other as noted by Client). Please release the following:
_____ Information necessary to coordinate service.
_____ Psycho-diagnostic assessment DSM-IV-R or DSM-5, ICD-10 or ICD-11
_____ Medical history and diagnosis
_____ Treatment
_____ Other Information as noted:_____

This information is confidential and may not be further disclosed without written consent unless otherwise provided for in Federal and State regulations. I, Client, understand that I may revoke this consent in writing at any time. This consent expires one year from the date below or whenever revoked by Client in writing, whichever comes first.

Client (or Legal Guardian's) Signature: _____Date_____

Client Full Name (printed):_____
(14 Pt. as required by CA BBS law) is entitled to a copy at any time so requested.