Roxanne Strauss Therapy
4700 Spring Street, La Mesa, CA 91942
Tel. 619-987-1790
www.roxannestrausstherapy.com

Authorization to Release Confidential Information

I hereby request and authorize _____
doctor, therapist, school, agency, etc.

_____
street address city state zip

and Roxanne Strauss, LMFT to exchange the following information:

_____ Any and All Information Necessary

_____Diagnosis _____Treatment Plan _____Prognosis

_____Progress to Date _____ Clinical Test Results _____Dates of Treatment

_____Patient Records _____Summary of Treatment

_____Other _____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid for: **6 months** **12 months**

_____ _____
Name of Client Date of Birth

_____ _____
Signature Date Signed

_____ _____
Name of Client Date of Birth

_____ _____
Signature Date Signed

Relationship to client if signed by individual other than client _____

I would like a copy of this release: _____Yes _____No

NOTICE TO RECEIVING FACILITY/THERAPIST:

- You may not disclose any of this information unless the person who consented to this disclosure specifically consents to such disclosure.
- I understand that there is a potential for re-disclosure of this information by the recipients and, if that occurs, the information may not be protected by federal law.