KIM FARBER PhD, LMFT
PSYCHOTHERAPY INDIVIDUALS, COUPLES, AND FAMILIES

lic. #82013
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Authorization to Release Confidential Information

I [Name of Client] ______________________ hereby authorize Dr. Kim Farber, LMFT (lic. #82013) to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to which the information is being released] ______________________________.

The Authorization permits the release of the following information:

____ And and All information necessary
____ Diagnosis
____ Treatment Plan
____ Prognosis
____ Progress to Date
____ Dates of Treatment
____ Patient Records
____ Summary of Treatment
____ Clinical Test Results
____ Other (specify) __________________

I authorize the release of the information described above for the following purpose(s):

____
____

The specific uses and limitations on the types of information to be released are as follows:

____
____

The specific uses and limitations on the use of the information by Recipient are as follows:

____
____

The Authorization shall remain valid until: __________________________________

I understand that I have the right to revoke this authorization, in writing, at any time. I understand the revocation does not apply to information already released in accordance with this authorization.

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I understand it is my right to obtain a copy of this authorization. I have read and understand the terms of this authorization. By my signature I voluntarily give consent to disclose information in the manner described above.

By: ________________________________ Date:_______________________________
(Client or Client's Representative*)

Authorized Recipient Contact Information

Name:

____

Phone:

____

Address:

____
____
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