AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name

_____

I authorize Valentina Masse, LMFT and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I have received and reviewed psychotherapy privacy policies.

I understand that by signing this authorization I am authorizing Valentina Masse to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the position of the persons and entities listed below may be disclosed to Valentina Masse. My health information includes any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient, and may no longer be protected by psychotherapy confidentiality rules.

My authorization is valid until_____, or until psychotherapy treatment file is finished.

_____

Name Address Client Initials

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Name Address Client Initials

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Name Address Client Initials

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Name Address Client Initials

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Client Signature Date