Linda A. Fasan, LMFT
Licensed Marriage and Family Therapist
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# Consent for Release of Confidential Information

Patient Name: _____

I hereby authorize the release and exchange of medical information pertaining to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment between Linda Fasan, LMFT and:

_____

_____

I authorize the release and exchange of this information via medical records (hard copy) and telephone communication. I understand that the exchange of this information is to permit the monitoring of my health status and to coordinate all medical and/or psychological care that I receive. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked the authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only.

Patient or Guardian Signature: _____

Date:_____/_____/_____

Client Signature: _____

Date:_____/_____/_____