Elizabeth Cappelletti, M.A., LMFT

Licensed Marriage & Family Therapist

Lic# 48524

949-310-6460 e-mail: elizabethloz@mac.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Elizabeth Cappelletti, LMFT by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _________________ authorize Elizabeth Cappelletti, LMFT to:
_____ release to:
_____ obtain from:
__X__ exchange with:
____
____
____
____

the following information pertaining to myself:
__X__ treatment summary
__X__ history/intake
__X__ diagnosis
____X_ psychological test results
___X__ psychiatric evaluation/medication history
___X__ dates of treatment attendance
_____ other (specify) _____________________________

for the purpose of:
___X__ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event ____.

Client Name:______________

DOB___________________________
Signature of Client ____________________________ Date _______________________

Signature of Parent ___________________________ Date _______________________

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