Jenna (Jennifer) Gross LMFT #125148
280 E. Thousand Oaks Blvd. Suite D
Thousand Oaks, CA 91360
(805) 399-9167

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, [Name of Patient] ____

hereby authorize [Name of provider] ____

To exchange confidential information regarding my treatment with:

____
Name

____
Street Address

____
City, State, Zip

____
Telephone number and/or fax number

This authorization permits the exchange of 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 authorize the exchange of the information described above for the following purpose(s):
____
____

The recipient may use the information described above solely for the following purpose(s):
____
____

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 until: ________________________ (expiration date).

By: ____ Date: ________________________
(*Patient or patient's representative*)

* If signed by other than patient, please indicate the relationship between patient and his/her representative: