Jennifer R. Fedorov, LMFT
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Authorization to Release Confidential Information

Re: _____ Birthdate:_____/_____/_____

This will authorize Jennifer R. Fedorov, LMFT, to release information and to receive information to and/or from:

Name:_____Phone number:_____

The information to be disclosed includes:

--------Evaluation and Diagnosis
--------Treatment Goals and Results
--------Progress Notes
--------Treatment Summary
--------Medications used in Treatment
--------Information about drug and/or alcohol abuse

The Information is needed for the following purposes:

----------Diagnosis and Evaluation
----------Treatment Planning
----------Continuity of Care
……Other

I may revoke this release, in writing, at any time, except to the extent that action has been taken in reliance thereon.

Signature of client:_____

Date:_____