AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, on behalf of _____,
(name of client/name of parent or guardian if applicable) (if applicable write minor's name)

hereby authorize Cynthia (Thea) Stanford, LMFT to ☐ Request & receive the following indicated information

☐ Disclose or release the following indicated information

To/From: _____
(Name of program/agency or provider and contact information)

Please Select Information as Applicable:

☐ My mental health record in its entirety
☐ My substance abuse record in its entirety
☐ My medical record in its entirety
☐ School records
☐ Specify information to be requested/disclosed: _____

_____	_____	_____	_____
Signature of Client	**Print Name**	**DOB**	**Date**

_____	_____	_____
Signature of Parent/Guardian	**Print Name**	**Date**