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Authorization to Release Confidential Information

By signing this document, I_____,
hereby authorize, Carol A. Kaye MFT, License# 52970, to disclose information and/or obtain records in the course of my treatment to/from:

_____, _____
(Name of receiving party) (Function/relationship to client)

Address:_____Phone:_____

I understand that I have a right to receive a copy of this authorization. I also understand that I have a right to cancel this authorization, and that any cancellation or modification of this authorization must be in writing. This disclosure of information or records authorized herein is required for the following purpose: _____

_____

_____.

Such disclosure shall be limited to the following specific types of information: _____

_____

_____.

This authorization shall remain valid until:_____.

Signature (s)_____

_____

Dated: _____