AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

RE: (Name) _____

Date of Birth _____

I hereby authorize:

Sheila Marshall, LMFT, PPS
818 N. Mountain Ave. Ste 219
Upland, California 91786
909-437-0765

to disclose or release information below to :

_____
_____
_____
_____

Disclosure shall be initiated to the following specific types of information which are considered instrumental in the ongoing evaluation and treatment of the individual:

_____

_____

_____

I understand that I may revoke this consent at any time, except to the extent that this is already been acted upon prior to my revocation. This consent will become null and void at the end time that services are being rendered or one year from date signed.

I am fully aware that before my records may be released, I must give my consent. I may refuse to sign this release and having been made aware of State and Federal statues, I voluntarily and knowingly sign this consent.

_____ _____

Signature Date