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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize **Paul Iarussi,** M.A., LMFT Associate to:
(print your name)

(Check all that apply)

_____ release to: _____
Professional's name/Agency name

_____ obtain from: _____
Address

_____ exchange with: _____
Phone Number

the following information pertaining to myself:

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, OR on the following earlier date, condition, or event (specify as follows):

_____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Signature of Client Date