Holly Lien, MA, LMFT LICENSE # MFC 35076 1736 Picasso Ave., Suite A, Davis, CA 95618
Holly@HollyLien.com (530) 220-3433 Specializing in Individual & Family Therapy, Adolescents, & Adoption

Authorization for Release of Information

I, _____, authorize _____
(client's full name) (therapist)

to have a mutual exchange of information with _____
(name of individual / company)

for the purpose of enhancing and collaborating services, approval of coverage, authorization, and processing claims. The following specific information from my records and course of treatment may be released:

> **Demographic information, psychosocial history, symptoms, diagnosis, treatment plan, prognosis, recommendations, and all similar information written and/or verbal via fax, phone and/or email.**

This consent may be revoked by me at any time, but ending the consent will not cancel any action that has already been taken as followed by the form. This consent to release information will expire one year from the date of signing or

_____
(date, event, or condition upon which it will expire)

_____ _____
(Signature) (Date)

☐ **Client**
☐ **Parent/Guardian**

_____ _____
(Witness) (Date)