LEHMAN THERAPY

JULIE LEHMAN, MS, LMFT #109200

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Integrative Counseling Services by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Julie Lehman, MS, LMFT to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

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 _____ _____. (See back for authorization extension).

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).

_____ Date of Birth:_____
Signature of Client Date

_____
Signature of Witness Date