Client Name____________________________

Erin Pensinger, MA, MFT
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650.281.9894

AUTHORIZATION FOR RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

I, ________________________________ hereby authorize Erin Pensinger, MFT and/or _______________________
(Client)

to:
- ☐ release information to
- ☐ obtain information from
- ☐ exchange information with

Name: ____

Agency: ____

Address: ____

Telephone/Fax: ___________________________________

Specific information to be released:
Initial each category that applies, and write "N/A" where applicable:

_____ Dates of treatment
_____ Treatment summary
_____ Letter(s) of support
_____ Psychological assessment/ Testing results
_____ Psychiatric and counseling record
_____ Oral communication & consultation as needed
_____ Drug and substance abuse history
_____ Educational assessment/ consultation
_____ Other as specified: ___________________________

For the following purpose(s):

- ☐ Coordination of treatment/care
- ☐ Employment, academic, legal, or administrative considerations
- ☐ Submission for Insurance Coverage
- ☐ Other as specified: _____________________________

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that 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.) This revocation must be delivered in writing to each of the treatment providers listed above.

****THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM DATE OF YOUR SIGNATURE****

____ ____
Signature of Client **Date** **Signature of Client's Guardian**

____ ____
Printed Name of Client **Date** **Printed Name of Client's Guardian**