

Information Release Agreement (optional)

Client Name _____ Date of Birth _____

Information:

I give my permission for **Sara Crain, MA, MFT** to obtain and release information about

_____ with the following agency or individuals:

Person and/or organization

Address

Telephone Number

Confidentiality:

The clinician will notify the client any time information is sought from or by another individual or agency, and will request only that information felt to be essential for best client treatment. This release is valid for one year from date of request.

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

Client (Parent or Guardian)

Date of Request

Therapist

Date