Offices of Estee Diamond, MS, LMFT
email: esteediamondlmft@gmail.com
Tel. 818-380-1521

AUTHORIZATION TO RELEASE AND SHARE CONFIDENTIAL INFORMATION

Since all communications made within the confines of our psychotherapeutic relationship are confidential, it is necessary for this office to request a signed authorization in order to release, share or obtain any information about your treatment.

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

AUTHORIZATION BETWEEN PARTIES:

Name: _____	AND	ALLISON ROSENBERG, MAC, AMFT
Address: _____		17337 VENTURA BL, STE 327
_____		ENCINO, CA 91316
Tel. _____		TEL. 818-724-9385
Email: _____		AlliesRosenberg@gmail.com

I, _____ (hereinafter "patient") hereby authorize Allison Rosenberg, MAC, AMFT (hereinafter "provider") to disclose mental health treatment information, records obtained in the course of psychotherapy treatment of patient, including, but not limited to, diagnosis, treatment planning, and progress.

I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless provider has take action in reliance upon it. I also understand that such revocation must be in writing and received by provider at 17337 Ventura Bl., Ste. 327, Encino, CA 91316.

The specific uses and limitations of the types of medical information to be disclosed are as follows:

_____

_____

This authorization shall remain valid until: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____