



204 G Street, Suite 205 Petaluma, CA 94952 | 707-765-2635

Request Information

I hereby request

Name and agency, if applicable

Address

E-mail address

Phone

Fax

to release any and all relevant psychological, medical, academic, legal and/or personal information, written or verbal, to Carol Harvey, M.F. T. Unless otherwise noted the purpose of this release is to gather information that may benefit my therapy or the therapy of my minor child.

Limitations (if any): _____

client date

client date

client date

parent or guardian (if client is under 18) date

Authorization to Release

I hereby request and authorize Carol Harvey, M.F.T. to release any and all information, written or verbal, regarding my therapy (or the therapy of my minor child) to:

Name and agency, if applicable

Phone

Fax

Purpose: _____

Unless otherwise noted above the purpose of this authorization is to provide for a coordination of services.

Limitations (if any): _____

One or both of the above authorizations may be modified or revoked, at any time, in writing. Authorization expires 1 year from date signed. I understand that I have a right to a copy of this authorization.

client date

client date

client date

parent or guardian (if client is under 18) date

CLIENT NAME: _____

birth date: _____