



Petaluma, CA 94952 | 707-765-2635

## 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): \_\_\_\_\_

\_\_\_\_\_

This authorization 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