Carol Harvey MFT

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): ____

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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