SIERRA PSYCHSOLUTIONS
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Authorization to Release Confidential Information

I, _____ hereby authorize

SierraPsychSolutions/_____LMFT
to release confidential information obtained during the course of my treatment to:

_____

This Authorization permits the release of the following information:

____ Diagnosis ____ Treatment Plan ____ Progress to Date ____ Prognosis ____ Clinical Test Results
____ Dates of Treatment ____ Any and All Information Necessary
____ Other (specify)

I authorize the release of the information described above for the following purpose(s):
The specific uses and limitations on the types of information to be released are as follows:
_____
_____
_____

The specific uses and limitations on the use of the information by Recipient are as follows:
_____
_____
_____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.
The Authorization shall remain valid until _____.

Patient Name:_____

Signature of Patient or Patient's Representative_____

Date:_____