Healing Inspiration with Olivia Fae Stadler

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Authorization to Release Confidential Information

I, [Name of Client] _____
hereby authorize Olivia Fae Stadler, Marriage and Family Therapist, to release confidential information obtained during the course of my treatment to: [name] _____
[phone number]_____
[email address] _____

This Authorization permits the release of the following information:
____ Any and All Information Necessary
(or limited to): ____Diagnosis ____Treatment Plan
____Progress to Date ____Prognosis ____Clinical Test Results
____Dates of Treatment ____Other (specify):

I authorize the release of the information described above for the following purpose(s): ____Coordination of care with other health care provider
____Other (specify):

The specific uses and limitations on the types of information to be released are as follows: ___Any and All Information ___Other (specify):

The specific uses and limitations on the use of the information by Recipient are as follows: ___Any and All Uses ___Other (specify):

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: _____
[Expiration Date]

By: _____ Date: _____
[Client Signature]