Uplifting Therapy
Licensed Marriage and Family Therapist
Lic. # LMFT 96217
PH: 530.645.2278 FAX: 530.671.1082

Authorization to Release Confidential Records and Information

I, _____ ("Patient") hereby authorize Brenda Franks, LMFT ("Provider") to release confidential information obtained during the course of my treatment to

_____

[name or function of the person(s) or entities to whom information is to be released] ("Recipient").

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: _____ ("Expiration Date")

500 Olive Street Ste. 28 Marysville, CA 95901
Email: brendacfranks@gmail.com

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I have had this form explained to me and I fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken.

_____ _____ _____
Signature of client Printed Name Date

_____
Signature of parent/guardian/representative

_____ _____ _____
Printed Name Relationship Date

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