Cathy Della Valle, LMFT #50034
2400 Las Gallinas Ave. #160 San Rafael, CA 94903 Tel:415-250-8114

Authorization to Release or Exchange Information

I authorize Cathy Della Valle, Licensed Marriage & Family Therapist, and:

Provider Name:_____

Address:_____ Phone:_____

_____ Email:_____

To release or exchange confidential information obtained about:

Clients' Name:_____ Date of Birth:_____

This Authorization permits release of any and all necessary information, including but not limited to, medical records, psychological testing, treatment history, functioning symtoms, diagnosis, prognosis, treatment plan, progress to date, medication records, dates of treatment, treatment summary, social services, school reports, etc. This information is to be used for evaluation , diagnosis, treament planning, treatment, and/or case coordination.

This Authorization has the following exceptions:_____

_____

This information may be exchanged verbally or in writing between or among these providers and will not be released to any other person or organization without my written consent.

A photocopy of this Authorization is as valid as the original. This Authorization shall remain valid until

_____or until a cancellation or modification of this Authorization is submitted in writing to this provider.

Signature:_____ Date:_____
(client)

Signature:_____ Date:_____
(parent/guardian)

Signature:_____ Date:_____
(parent/guardian)

Signature of Provider_____ Date:_____

*You have a right to receive a copy of this form. Please let me know if you would like a copy.