AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Lana Pivovar M.A. LMFT
Licensed Marriage & Family Therapist | License No. 104015
3175 Sunset Blvd. | Suite 104 | Rocklin | CA | 95677 | 916-761-7165

Client's name _____

I, _____ hereby authorize Lana Pivovar to release or
(Full Name of Client or Guardian)

obtain information as specified below:

Obtain Information from: _____
_____
_____

Release Information to: _____
_____
_____

The following information may be included:
Entire Record
Diagnosis
Treatment Summary
Legal Information
Individual Treatment Plan
Telephone Consent
Other (Please Specify): _____

This authorization is given of my own free will and is in the effect for one year from the date bellow unless dates are specifically stated. I understand that I can revoke this authorization in writing at any time.

_____ _____
Signature of Clients (Parent/Guardian if minor) Date

_____ _____
Date

_____ _____
Witness Date