Cheryl Heinla, MA, LMFT
CA License 90412
1610 Oak Park Blvd, Suite 208
Pleasant Hill, CA 94523
Tel: 925-324-1332 ~ Email: CherylHeinlaMFT@gmail.com

***Authorization to Release and/or Exchange Confidential Information***

I, _____(Client), hereby authorize Cheryl Heinla, LMFT (Provider) to release and/or exchange confidential information obtained during the course of my treatment to/with:

_____(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:

_____

_____

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: _____ (Date)

By (Client or Client's Representative/parent/guardian) signature: _____

Name Print _____ Date: _____