Michele Saffier, LMFT, CSAT
Licensed Marriage and Family Therapist

Authorization for Release of Healthcare Information

Date: _____ / _____ / _____

I _____ Permit _____ to obtain and/or relase my:

____ Progress ____ Evaluation

____ Treatment Summary ____ Other (Specify) _____

From and/or to _____

Phone Number: _____

Address: _____

For the purpose of: _____

To be restricted to: _____

To terminate on: _____

By signing below, I state my understanding that I may revoke this authorization at any time except after the above material has already been obtained or released pursuant to my prior authorization.

This authorization will expire one year from the above date, unless specifically stated to the contrary.

Patient / Guardian: _____

Date: _____

Witness: _____

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