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LICENSED MARRIAGE
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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, [Name of Client] _____ hereby authorize **Denise J. Hockley, LMFT** to
_____ release or
_____ exchange

confidential information obtained during the course of my treatment to _____

Name, Professional Title and Phone: _____

Address: _____

This Authorization permits the release of the following information:

- ____ Diagnosis ____ Treatment Plan ____ Prognosis
- ____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment
- ____ Client Records ____ Summary of Treatment ____ Other

I authorize the release of the information described above for the following purpose(s):

The recipient may use the information described above solely for the following purpose(s):

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____ (“Expiration Date”)

By: _____ Date: _____

(Client or Client’s Representative*)

*If signed by other than Client, please indicate the relationship between Client and his/her

Representative: _____