



Authorization to Obtain or Release Confidential Information

I _____, authorize Dani Graziano, MFT to release / obtain information that is pertinent to my therapy or evaluation with any person/s or staff of clinic, office, agency or institution/s named below.

1. _____

Agency/Doctor's Name	Phone	Address
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2. _____

Agency/Doctor's Name	Phone	Address
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3. _____

Agency/Doctor's Name	Phone	Address
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Reason(s) for the release of information:

- Consultation/Psychotherapy
 Evaluation
 Other: _____

This consent is in effect for one year from the date of signing, unless revoked in writing or until the termination of therapy. I understand that I may revoke this consent at any time. I understand that any cancellation or modification of this authorization must be in writing.

Client Signature	Name (print)	Date
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Client Signature	Name (print)	Date
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