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AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Patient Name:_____DOB:_____

I, the undersigned, hereby authorize Carol Cochrane Bass, LMFT to release or exchange information pertaining to my therapeutic issues and concerns with:

Provider's Name: _____

Phone/Address: _____

Information To Be Released or Exchanged:

___ Medical information and/or records, including medication history

___ Psychiatric/therapeutic information and/or records

___ Psychological testing and evaluation results

___ Other: (specify) _____

Patient Signature Date

This consent is subject to revocation or modification in writing by the Patient at any time except to the extent that action has been taken in reliance hereon. If not revoked or modified, this consent shall terminate on_____. (date of revocation, if any.)