THERAPY *WITH* EVAN

CONFIDENTIAL

Release of Information

office use only **Client #** _____

I/We, ____ **(Client[s] or Representative[s]),**
hereby authorize **Evan Loofbourrow, LMFT #123801**
to exchange confidential information pertinent to treatment with the **Recipient(s)** named below:

Recipient ____
e.g. school counselor, therapist, physician, psychiatrist, social worker, teacher, parent, sibling, partner, clinic, office, agency, etc.

Recipient Address ____

Recipient Email ________________________________ Recipient Phone # ________________________

Information released to be used for ____
e.g. professional consultation; treatment/care coordination; third-party payment responsibility; insurance benefit, medical disability, or social security claim; emergency support, etc.

> *(optional)* Note any **restrictions, limitations, or exclusions** to place on this Release of Information:
>
> ____
> *e.g. Release only dates of service or payment records/balance due; do not discuss diagnosed conditions; release only a summary of treatment, etc.*

All parties signing below (*with ink or a digital signature*) affirm their understanding that:

(i) They have the right to modify or revoke this Release at any time.
(ii) Any change to this Release must be in writing.
(iii) Unless modified or revoked, this Release shall remain valid for one year from date of signing, or until the termination of therapy.

Client Signature ____ Date ________________

If Applicable:

Client 2 Signature ____ Date ________________

Client 3 Signature ____ Date ________________

Client 4 Signature ____ Date ________________

If signing for Client(s):

Representative Signature ____ Date ________________

Relationship to Client(s) ____