Denise Carr, MS, LMFT
Licensed Marriage and Family Therapist
AUTHORIZATION TO RELEASE INFORMATION

By signing this document, I, _____, (hereinafter "Client" or Client's parent/guardian) hereby authorize DENISE M. CARR, (hereinafter "Provider") to disclose and mutually exchange any and all mental health treatment information and records obtained in the course of the Provider's treatment of _____ (Client) including, but not limited to my (or my child's) social, emotional, educational, religious, psychological and medical histories, including assessments, background, opinions, and any other relevant data necessary to assist DENISE CARR in providing continuing service to myself or my child, TO:

Name_____ Function _____
Address_____ Telephone _____
_____ Fax _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 540 Pennsylvania Avenue, Suite 325, Fort Washington, PA 19034 to be effective.

This disclosure of information and records authorized by Client is required for the following purpose:

____Treatment planning
____Treatment coordination
____Other (specify) _____

I agree to indemnify and hold harmless all persons named above from any and all liability claims, actions, damages or suits arising from or relating to the release or exchange of information made pursuant to this authorization to release confidential information.

Provider shall not condition treatment upon Client signing this authorization and client has the right to refuse to sign this form

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable Pennsylvania law may protect such information.

This authorization shall remain valid until: _____

Patient's signature: _____ Date: _____