Kyra F. Riddell, MA
Licensed Marriage and Family Therapist, Lic. 98921

RELEASE OF INFORMATION

I/We hereby authorize my therapist: _____
(therapist's name)

to release or receive information regarding:

_____
(print client's full name and date of birth)

to/from _____
(name/s)

_____
(address)

_____ _____ _____
(city) (state) (zip code)

_(____)_____ _(____)_____ _____
(phone number) (fax number) (e-mail address)

for the following specific purpose:

_____

_____.

Such information will be kept confidential and be limited to that necessary for treatment unless otherwise stated. The information received will not be used for any purpose other than its intended clinical use. This authorization shall be valid until _____. No greater amount of information will be disclosed than is necessary to achieve the above specific purpose. I may request a copy of this authorization for my records and may revoke this authorization at any time.

_____ Client's Signature _____Date

_____ Client's Signature _____Date

Kyra F. Riddell, MA, LMFT Lic. 98921
Phone (805) 669-8115 ~ Fax (805) 309-2469
Kyrariddell.lmft@gmail.com