**Jennifer Lucas, LMFT**

**160 W Center Street Promenade #112**

**Anaheim, CA 92805**

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided Jennifer Lucas, M.S., LMFT by other individuals or agencies. Such requests should be referred to the original individual or agency. I _____ authorize Jennifer Lucas, LMFT to: _____ release to: _____

obtain from: _____

exchange with: _____

_____

_____

the following information pertaining to myself:

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____
_____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Social Security #:_____ Signature of Client:_____Date_____