Wilshire Valley Therapy Centers/ Pacific West Counseling Center
NAME OF THERAPIST:
Authorization to Release Confidential Information

By signing this document, I, _____,

hereby authorize _____, my psychotherapist,

to disclose information and/or records obtained in the course of my treatment to:

_____, _____
(Name of receiving party) (Function/relationship to client)

Address:
_____Phone:_____

I understand that I have a right to receive a copy of this authorization.

I also understand that I have a right to cancel this authorization, and that any cancellation or modification of this authorization must be in writing.

This disclosure of information or records authorized herein is required for the following purpose: _____

_____

_____.

Such disclosure shall be limited to the following specific types of information:

_____

_____.

This authorization shall remain valid until:_____.
(Enter authorization expiration date here)

Signature (s)_____

_____

Dated: _____

**Wilshire Valley Therapy Centers/ Pacific West Counseling Center –**
**wilshiretherapy@gmail.com * www.wilshirecenter.net**