



AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, the undersigned, hereby authorize Cal Domingue, MFT (MFC39338) to release confidential information obtained during the course of my treatment, and to obtain confidential information regarding my treatment, with:

Name: _____

Relationship: _____

Address: _____

Phone: _____ Email: _____

This authorization permits release of the following information, by either party:

Any and all information necessary	Treatment Plan
Diagnosis	Clinical Test Results
Progress to Date	Summary of Treatment
Patient Records	Prognosis
Dates of Treatment	
Other:	

I authorize the release of the information described above for the following purposes:

The recipient may use the information described above solely for the following purposes:

I understand that I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be made in writing, and can be sent to:

Cal Domingue, MFT
P.O. Box 460732
San Francisco, CA 94146-0732.

This authorization shall become effective immediately and shall remain in effect until _____ (“Expiration Date”).

Client Name (please print): _____

Address: _____

Street

City

Zip

Home Phone: _____ Work/Mobile: _____

Signature: _____ Date: _____

If signed by other than client, please indicate representative's name & relationship:
