Dawn Delgado, LMFT

COMPASSIONATE, EFFECTIVE PSYCHOTHERAPY

Authorization for Release of Protected Health Care Information

This authorization is valid until revoked by the client or until discharge. Client's signature provides consent for the release of information pertinent to treatment of:

_____
(Name of client)

Name of provider:_____

Type of professional services:_____

Business phone:_____ Fax:_____

Please check all that apply:
□ Mental Health assessments and treatment plan.
□ Psychiatric evaluation and treatment plan.
□ Nutrition evaluation and treatment plan.
□ Medical evaluations, history and treatment plan.
□ Discharge summary and recommendations.
□ Phone communications for reports of progress, compliance, participation.

_____
Client signature Date

_____
Dawn Delgado, LMFT #44242 Date

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