AUTHORIZATION TO DISCLOSE CLIENT INFORMATION

I, _____, authorize Wendi L. Dumbroff, MA, LPC, to disclose/receive information pertaining to my treatment to/from the following individual(s):

_____

_____

The information exchanged acknowledges the therapeutic relationship and is limited as follows:

_____

_____

_____

The information is disclosed/received in the interest of the client for following purpose(s):

1. Collaboration with a treating psychiatrist
2. Collaboration with another therapist currently providing other services
3. Collaboration with another therapist who has treated the client
4. Contact to enlist a family member as a resource for change, or for the purpose of scheduling appointments, or for being able to acknowledge the client is being seen by this therapist
5. Contact with a family member to alert them to health and safety concerns about the client
6. Other:_____

Client's Signature _____ Date _____

Parent's/Guardian's Signature
If client is a minor _____ Date _____

Therapist's Signature _____ Date _____

Signatures of Family/Partner (1)_____ Date _____

(2)_____ Date_____ (3)_____ Date_____

(4)_____ Date_____ (5)_____ Date_____

Revocation: I hereby revoke this authorization

Client's Signature _____ Date _____