

**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 \_\_\_\_\_