Authorization For Release and/or Disclosure of Mental Health Information

Please **REQUEST** Mental Health Information **From**:	Please **SEND** Mental Health Information **To**:
Name of Provider to Release Information:	Name of Person to Receive Information:
Kristina de Bree, LMFT #98046	
Address: **25000 Avenue Stanford #161** **Valencia, CA 91355**	Address:
Phone Number: **(661) 513-4857**	Phone Number:
Email: **therapywithkristina@gmail.com**	Email:

I hereby authorize **Kristina de Bree, MA, LMFT #98046** to release and/or disclose the mental health information as indicated below to the health care provider, entity, or person I have indicated above. Release and/or disclose records and information regarding:

Name of Client: _____ Date of Birth: _____

Full Address (including city/state/zip):

_____

_____

Telephone Number: _____

Duration: This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Information To Be Released: _____

_____

_____

_____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects by wishes. I have the right to receive a copy of this authorization - A copy is valid as the original.

_____	_____	_____
Date	Signature of Client or Parent of Minor	Relationship to Client

Authorization For Release and/or Disclosure of Mental Health Information

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Phone Number:	Phone Number: **(661) 513-4857**
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