Roxanne Strauss Therapy
4025 Camino del Rio S. #326, San Diego, CA 92108
Tel. 619-542-7703
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Authorization to Release Confidential Information

I hereby request and authorize ____
doctor, therapist, school, agency, etc.

____
street address city state zip

and Roxanne Strauss, LMFT to exchange the following information:

_____ Any and All Information Necessary

_____Diagnosis _____Treatment Plan _____Prognosis

_____Progress to Date _____ Clinical Test Results _____Dates of Treatment

_____Patient Records _____Summary of Treatment

_____Other ____

____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid for: **6 months** **12 months**

________________________________ ____________________
Name of Client Date of Birth

________________________________ ____________________
Signature Date Signed

________________________________ ____________________
Name of Client Date of Birth

________________________________ ____________________
Signature Date Signed

Relationship to client if signed by individual other than client ___________________