

Franci Smith, M.S., LMFT, LPCC
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
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Authorization to Release/Exchange Confidential Information

I, _____ hereby authorize Franci Smith, MFT, to
Release and/or Exchange confidential information obtained during the course of my treatment with

(Name or function of the person(s) or entities to whom information is to be released/exchanged)

This Authorization permits the release and/or exchange of the following information:

- Diagnosis Treatment Plan Progress to Date
 Prognosis Clinical Test Results Dates of Treatment
 Any and All Information Necessary
 Other (specify)

I authorize the release and/or exchange of the information described above for
the following purpose(s):

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____ or one year from today's date.
(expiration date)

By: _____ Date: _____
(Client or Parent/Guardian if under the age of 18)

*If signed by other than Patient, please indicate the relationship between Client
and his/her Representative.