Karron Maidment, RN, LMFT
Licensed Marriage and Family Therapist
MFT# 41914
Telephone 310 285 2280
1923 1/2, Westwood Blvd. Suite 2. Los Angeles, CA 90025

Consent for Release of Information

Name:_____ Birth Date:_____

I hereby authorize Karron Maidment, LMFT to request and exchange confidential information regarding my treatment with the following:

Name: _____

Address:_____

Phone:_____ Fax:_____

This Authorization permits the exchange of the following information:

Mental Health _____ Any and All Information Necessary_

Diagnosis ____ Progress to Date ____ Patient Records____ Treatment Plan ____
Prognosis ____ Clinical Test Results ___ Dates of Treatment ___ Discharge Notes____
Treatment summary____ Other:(specify)_____

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

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.

Client name:_____ Date:_____

Signature of client/parent/guardian/conservator:_____

If signed by someone other than client indicate relationship:_____