

EVA VAN PROOYEN

MARRIAGE & FAMILY THERAPIST

Release of Information

AUTHORIZATION TO RELEASE RECORDS

I/We _____, hereby authorize _____ and Eva Van Prooyen, MFT to exchange (use of the word "exchange" allows information to flow back and forth) my health records and confidential information obtained during the course of treatment.

This disclosure of such records authorized herein is required for the following purpose(s):

- Treatment Coordination
- Billing
- Other:

Such disclosures shall be limited to the following specific information:

- Any and All Information Necessary
- History
- Assessment
- Diagnosis
- Treatment
- Prognosis
- Dates of Treatment
- Treatment Records or Summary

I UNDERSTAND I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION, AND ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST BE IN WRITING.

This consent shall expire one day after the date of the termination of therapy unless otherwise specified. You may request a copy of this release.

Client's Signature

Date

Client's Signature

Date

Therapist's Signature

Date

