

P. Delia Brinton, MFT
License #MFC 38911
100 Tamal Plaza, #108
Corte Madera, CA 94925
Phone: 415. 924. 2638 Fax: 415.924.1638

AUTHORIZATION TO RELEASE INFORMATION

This form has been created to protect your rights to confidentiality. Please note that the form specifies with whom information about you may be exchanged and for what purpose. This is considered a reciprocal agreement. All blanks should be filled in before you sign it. You are entitled to receive a copy of this completed form.

I authorize Delia Brinton, MFT, to exchange information with _____
_____ in regard to (whom) _____

for the purpose of (check that which is applicable):

Consultation

Medical/treatment history

Other _____

Information requested: _____

Specific use of this information: _____

Specific limitations on the use of this information: _____

This is valid from the date signed but not beyond _____.
Date

Signature _____

Print Name _____

Address and City _____

Date _____

Exchanged with: Name _____

Address _____

Telephone _____ FAX _____

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I authorize _____ to release information to Delia Brinton,

MFT in regard to (whom) _____

for the purpose of (check that which is applicable):

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Medical/treatment history

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Signature _____

Print Name _____

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Information released from: Name _____

Address _____

Telephone _____ FAX _____

