Greta Angert, MFT

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, [Name of Patient] _____ hereby authorize Greta Angert, MFT to release confidential information obtained during the course of my treatment to:

Name_____ Name_____

Facility_____ Facility _____

Phone_____ Phone_____

Fax_____ Fax_____

Address_____ Address_____

Email _____ Email _____

Name_____ Name_____

Facility_____ Facility _____

Phone_____ Phone_____

Fax_____ Fax_____

Address_____ Address_____

Email _____ Email _____

This authorization permits the release of any or all information related to treatment planning, prognosis, diagnosis, clinical/medical test results, dates of treatment, progress to date, summary of treatment and any other clinical or medical information relevant to patient care.

X_____ Date: _____

Patient or Parent of a Minor

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