KATHERINE JEWETT LMFT
Licensed Marriage and Family Therapist
Thriving, not just surviving your life.
katherine@timetothrivetherapy.com●Ph.925-322-1681●MFT#100342
www.timetothrivetherapy.com

Request/Authorization to Release Confidential Records and Information

I hereby authorize:
Person or facility:_____

Address:_____Phone_____

to release information from records for_____ born on _____

to: Katherine Jewett, MA LMFT

Address: 395 Taylor Blvd. #220, Pleasant Hill, CA 94523

Phone: 925-322-1681

For following purpose:

- ❑ Further mental health evaluation, treatment, or care
- ❑ Rehabilitation program development or services
- ❑ Treatment planning ❑ Research
- ❑Other:_____

In the boxes below, the information to be disclosed is marked by an "X," the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

- ❑ Intake and discharge summaries ❑ Medical history and evaluation(s)
- ❑Mental health evaluations ❑ Developmental and/or social history
- ❑ Educational records ❑ Progress notes, and treatment or closing summary
- ❑ Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian/representative	Printed name	Date

Patient has the right to have a copy of this authorization.

❑ Copy for patient or parent/guardian
❑ Copy for source of records
❑ Copy for recipient of records