Laurie Friesen, LMFT
20412 Brian Way #1A
Tehachapi, Ca 93561
661-823-0661

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name_____ Date of Birth_____

I, _____, authorize communication between Laurie Friesen, LMFT and _____

This communication may include official reports and pertinent summary of the client's psychological and psychiatric history, including current condition, participation and progress in treatment, and recommendations. The purpose of such communication is:

__ the coordination of services

__ _____

I agree that a photocopy of this signed authorization shall be as valid as the original. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon. If not earlier revoked, this consent terminates on _____.

_____

Signature of Client Date

_____

Signature of Witness Date

_____

Signature of Parent, Conservator or Guardian Date