AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Lara LMFT Inc.

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LaraMFT@gmail.com

I,_____ (Requesting Client Printed Name) authorize "Provider" Lara Sayles, M.A., LMFT at Lara LMFT Inc to release to:

Recipient Name:_____
Profession/Relationship:_____ Phone:_____
Email:_____
Address:_____
_____
_____
the following protected health information:
_____
_____
_____
effective as of the following date:_____

I understand that I have a right to receive a copy of this authorization, and that any modification of it must be in writing. I understand that I have the right to revoke this authorization at any time. I also understand that such revocation must be in writing and received by Provider to be effective. Provider is authorized to disclose the protected health information specifically listed above until: _____(authorization expiration date).

Signature of Requesting Client:_____

Date:_____