Alisa Piette, LMFT.
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1264 Higuera St. #211
SLO, CA 93401

Authorization to Release Records

I,____________________, hereby authorize_____________________and

Alisa Piette, MFT to exchange my health records and information obtained during the course of treatment.

The disclosure of such records authorized herein is required for the following purpose(s):

Such disclosure shall be limited to the following use of information:

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Such disclosure shall be limited to the following type of information:

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This consent shall expire on:____

The patient can request a copy of this authorization. The patient has a right to refuse to sign this form. The patient understands that information that is used or disclosed according to this authorization may be subject to re-disclosure by the recipient. The provider will not make providing treatment a condition of signing this Authorization. The patient is entitled to receive a copy of this form. For revocation of this form, the Patient must provide a written request to the clinician named above. California law may provide additional protection regarding the possible re-disclosure stated above.

Signature of client: _____________________ Date __________________

Signature of parent : ____________________ Date___________________

Signature of therapist:_____________________________Date____________