

KEN NOGUCHI, LMFT
MARRIAGE & FAMILY THERAPIST
License #92408

Authorization to Release Confidential Information

I, [Name of Patient] _____ (“Patient”)
hereby authorize [Name of Provider] _____ (“Provider”)
to release confidential information obtained during the course of my treatment to [name or
function of the person(s) or entities to whom information is to be
released] _____ (“Recipient”).

This Authorization permits the release of the following information:

Diagnosis Treatment Plan Progress to Date
 Prognosis Clinical Test Results Dates of Treatment
 Any and All Information Necessary
 Other (specify) _____

I authorize the release of the information described above for the following purpose(s):

The specific uses and limitations on the types of information to be released are as follows:

The specific uses and limitations on the use of the information by Recipient are as follows:

I understand that I have a right to receive a copy of this Authorization, and that any
modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____ (“Expiration Date”)

By: _____ Date: _____ (Patient or
Patient’s Representative)

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5694 Mission Center Rd | Suite 602-892 | San Diego, CA 92108

T: (619) 909-7639 | F: (619) 815-4254

www.kennoguchilmft.com | info@kennoguchilmft.com