CAITLIN R. BURGESS, JD, MA, LMFT
Professional Clinical, Legal, and Forensic Services

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, the undersigned, hereby authorize Caitlin R. Burgess, JD, MA, LMFT (CA MFT #94485 and WA LF #61090853) and any of her clinical associates to exchange confidential information obtained during the course of my treatment, my family's treatment, co-parenting counseling, or my child's individual treatment with the following:

Name: ____

Phone: ______________________ Email: ______________________

This authorization permits release of the following information:

Any and all information necessary

Treatment Plan

Diagnosis

Clinical Test Results

Progress to Date

Summary of Treatment

Patient Records

Prognosis

Dates of Treatment

Other: ____

I authorize the release of the information described above for the following purposes:

____

The recipient may use the information described above solely for the following purposes:

____

I understand that I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be made in writing, and can be sent to: Caitlin R. Burgess, JD, MA, LMFT (CA MFT #94485 and WA LF #61090853), 319 Los Gatos-Saratoga Road, Los Gatos, California 95030. This authorization shall become effective immediately and shall remain in effect until one year from the date of the client and/or the authorized representative's signature (including parent or legal guardian) below.

Client Name (please print): ____

Parent Name (if applicable – please print): ______________________________

Address: ____

Phone: ___________________________ Work/Mobile: ______________________

Signature: _____________________________________ Date: _______________

Client has received a copy of this form (Check One): Yes No