Cory Wilkin, MS, LMFT
Licensed Marriage and Family Therapist
License#: MFC51433
27281 Las Ramblas, Suite 200
Mission Viejo, CA 92691
(949) 371-8080

Authorization to Release Confidential Information

I, (Name of Patient)_____ hereby authorize **Cory Wilkin, M.S.** to release confidential information obtained during the course of my treatment to (name and function of the person(s) or entities to which information is to be released)

_____

This authorization permits the release of the following information:

- ☐ Any and All Information Necessary
- ☐ Diagnosis ☐ Treatment Plan ☐ Prognosis
- ☐ Progress to Date ☐ Clinical Test Results ☐ Dates of Treatment
- ☐ Patient Records ☐ Summary of Treatment

- ☐ Other_____

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

_____

The recipient may use the information described above solely for the following purpose(s):

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid until the following date: _____

By: _____ Date: _____
(Signature of Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative: _____