

Sam Allen, MS, LGMFT

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 AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Sam Allen, MS, LGMFT, a marriage and family therapist in private practice at the above location, to release, and exchange information with:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name of individual(s) and/or agency from whom information is to be obtained)

at (address and/or phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

about myself or my child .

Additionally, I consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sharing,

 (Same name of above professional individual or agency)

releasing, and exchanging information with Sam Allen, MS LGMFT.

The information being released and shared will be used for treatment planning and co-ordination.

I understand that I may revoke this consent at any time except to the extent that action

has already been taken on it and that it will expire automatically by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (Date of expiration)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Parent (if client is a minor) Date