Authorization to Release Confidential Information

I hereby request and authorize
(Name of doctor, therapist, school, agency, etc.)
(Street address, city, state, zip code)
and Kimberly Miller, Associate Marriage and Family Therapist, Certified Internal Family Systems Practitioner, and Certified Imago Relationship Therapy Practitioner, to exchange the following information
(check all that apply below):
Any and all information necessary for coordination/continuity of care
Diagnosis Treatment Plan Prognosis Progress To-Date
Clinical Test Results Client Records Dates of Treatment Treatment Summary
I understand I have the 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 for Six Months Twelve Months (select one)
Client Name (Print) Date of Birth
Client SignatureDate Signed
Client Name (Print) Date of Birth
Client SignatureDate Signed
Relationship to client if signed by individual other than client:

Return completed form to: Kimberly Miller kimberly@kimberlyjunemiller.com 310 N. Indian Hill Blvd. Suite 506 Claremont, CA 91711