RubyVisions
Maria C. d'Avella, MFT
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Authorization to Release and Obtain Confidential Information

I hereby authorize Maria C. d'Avella, MFT to release and obtain confidential information regarding:

Client: Date of Birth:

The information will be disclosed and/or obtained from:

Telephone #: _____

The extent and nature of the information exchanged is limited to: Matters regarding mental health and well being.

The reason for releasing or obtaining the information: To facilitate treatment in the best interest of the client.

I hereby release Ruby Visions, Maria C. d'Avella, MFT, from all liability and all claims of any nature pertaining to the disclosure of information described above. This consent is subject to revocation at anytime by request of the client and will expire in one year from the date below, which ever occurs first.

Client Signature: _____ Date: _____

Name Printed: _____