Julie Machado, MFT
Licensed Marriage & Family Therapist, MFC27937
The Historic Linekin Building
22248 Main Street, Hayward, CA 94541
Phone 510-581-7850 • Fax 510-581-9668
www.JulieMachadoMFT.com

Authorization to Release or Exchange Confidential Information

I, (Name of Client or Parent/Guardian) _____hereby authorize **Julie Machado, MFT** to release and/or exchange with

_____

the following information (check all that apply):

____ Any information necessary ____ Diagnosis ____ Treatment Plan
____ Clinical Test Results ____Prognosis ____ Progress to Date
____ Summary of Treatment ____ Dates of Treatment ____ Client Records
____Other:_____ ____ Other:_____

contained in the records of (Client) _____
for the specific purpose(s) of:_____

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:_____ unless sooner canceled or modified in writing and delivered to Julie Machado, MFT by the client, parent or guardian.

Signed by:_____ Date: _____
(Client or Parent/Guardian*)

**If signed by other than Client, please indicate the relationship between Client and his/her Representative:*_____