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Consent To Release/Exchange Information

PATIENT NAME ________________________________ **BIRTHDATE** ________________________

I, ____ authorize Mimi Leung-Pang, LMFT
(Patient or Parent/Legal Guardian) (Professional)

____

to release the specific information as follows:

1. To disclose to/exchange with ____
(Professional)
2. Length of time the information will be kept before being destroyed or disposed of:
____
3. I understand that I may revoke this authorization at any time.

____

Printed (First Name, Middle initial, Last Name)

____ ____________________

Signature **Date**