Desiree Bowsher, MA, LMFT
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Authorization for Release of Information

I, _____, authorize Desiree Bowsher, M.A., LMFT to disclose/receive information to/from:

Person/organization name _____

Person/organization address _____

_____

Person/organization phone/fax number _____

_____ I do not wish to place restrictions on disclosure to above entity.

_____ I wish to place the following restrictions on disclosure to above entity:

_____

I understand that my records are protected under Federal and specific state confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time except to the extent that action has already occurred and has been taken in reliance on it, and that in any event this consent expires automatically as described below.

_____ This authorization expires at termination of therapy.

_____ I wish for this authorization to expire prior to termination of therapy as indicated:

_____.

I further acknowledged that the information to be released was explained to me and this consent is given of my own free will. I also understand that I have a right to receive a copy of this authorization.

_____ _____
(client, parent/guardian, or authorized person)signature Date

_____ _____
(client, parent/guardian, or authorized person)signature Date

_____ _____
Desiree Bowsher, M.A., LMFT Date