BROOKE M. SKLAR
PSYCHOTHERAPY

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (name) hereby authorize Brooke Sklar, LMFT to exchange clinical information relevant to your care with the individual or agency listed below:

Name: _____

Address: _____

Telephone: _____ Fax: _____

This agreement shall be valid from _____ to _____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my provider's address. However, my revocation or modification will not be effective until my provider receives it.

The provider will observe applicable rules of confidentiality regarding any information, written or verbal, that is received under this agreement. It is understood that this exchange and/or receipt of information is intended solely for the purpose of furthering treatment.

A photocopy of this authorization shall be considered as effective and valid as the original and I understand that I have a right to receive a copy of this document.

_____	_____	_____
Client Name (print)	Client Signature	Date

_____
Parent or Guardian Signature for Minor Clients