Doug Lerch MFT
7 Fourth Street Suite 46 Petaluma CA 94952
707-835-4106
douglerchmft@gmail.com

WAIVER- CONSENT TO RELEASE INFORMATION

Name of Client____

As the client named above, or as the guardian of a minor named above, I authorize the following agency, school, organization, and/or person to release information to Doug Lerch or Doug Lerch to release the information to the following agency, school, organization or person.

____

The information to be released from my records, or from those of my child named above, is to be limited to the following categories of information, indicated by a check mark:

[ ] Educational [ ] Psychiatric [ ] Medical
[ ] Social [ ] Psychological [ ] Psychometric

This authorization is temporary, and is valid only until counseling has been terminated. Persons who may be releasing information to me may call me (at the telephone number given above) to verify that this release is valid. The information released by any party is exclusively for Doug Lerch and is not to be provided to any other party without my written permission. This release allows my counselor and the other party releasing information to communicate with each other if deemed necessary by either party. In order that multiple requests may be made from one signed authorization, a photocopy of this signed authorization shall be considered valid.

____ ________________
Client Authorization Signature Date

____ ________________
Counselor's Signature as Witness Date

Information is requested from or being granted to:

____
Agency/School/Organization Contact Person

____ ________________________
Address City State Zip

Information may be sent to:

Doug Lerch

Attn:____ (marked confidential)

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