PERMISSION FOR RELEASE OF INFORMATION

Patient Name	Date of Birth	Social Security Number

Patient Address

Agency A/Persons A

Leticia Murphy, MFT, LADC
199 N. Arroyo Grande Blvd.,
Suite 100
Henderson, NV 89074
(702) 275-0473 Phone
(702) 450-1105 Fax

Agency / Persons B

_____
(Name, Title, Organization)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone Number)

To make the following transaction:

Regarding: _____.
(Client's Name)

I authorize the release of the following information: _____
_____

For the purpose of: _____
_____

This release is effective from _____ to _____.
(Month/day/year) *(Month/day/year)*

I understand that I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

Client Signature	*Parent/Guardian Signature*
Witness Signature	*Date*

NOTICE: This information has been disclosed from records which are confidential. Any further disclosure without the written consent of the person to whom it pertains exceeds the limit of this release.