

Elizabeth Crenshaw, LMFT, #32000
718 Spring Street
Santa Rosa, CA 95404
(707)775-9895

**AUTHORIZATION FOR RELEASE/EXCHANGE OF
CONFIDENTIAL MEDICAL INFORMATION**

Date_____

_____ is currently receiving services from Elizabeth Crenshaw, MFT.
(Client's full name)

I give permission for an exchange of information that will include relevant information regarding assessment, evaluation, diagnosis and treatment between Elizabeth Crenshaw, MFT and the following party:

Name

Address

This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken in reliance thereon and, if not earlier revoked. This consent expires on _____

(Date)

(Parent/Guardian/Client's Signature) _____ (Date) _____ Verified by Clinician