Tatra-Li de la Rosa, LMFT, 83945
865 Third Street, Suite 204
Santa Rosa, CA 95404
707-536-5069
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CONSENT TO RELEASE INFORMATION

I, ____________________________, authorize the release/exchange of information between Tatra-Li de la Rosa, LMFT, and the following person(s) and/or organization(s):

Name: ____

Address: ____

____

Phone: ____

All parties listed on this authorization are released within this consent form. Disclosure of the information authorized herein is required for the purpose of providing my therapist with information about my mental or physical health treatment by said provider. Disclosures between my provider and therapist may include all clinical records as well as verbal consultations.

This consent shall be in effect from this day ________________, 2021 for the duration of one (1) year. It is subject to revocation at any time. Revoking of this authorization will not cancel any prior action that has already transpired. A photocopy, facsimile, scan or duplicate of this authorization shall be as valid as the original.

____

Client Signature Date