Authorization to Release Confidential Information

Sydney Isley, M.A., LMFT #88861

DBA Chino Valley Therapist

I hereby authorize Sydney Isley, LMFT, DBA Chino Valley Therapist to disclose my mental health information to

This Authorization permits the disclosure of the following information:

☐Any and All Information	☐ Progress to Date
☐ Treatment Plan	☐Summary of Treatment
☐ Prognosis	☐Other

I authorize the release of the information described above for the following purpose(s) only:

I understand that I have a right to receive a copy of this authorization.

I understand that have the right to revoke this authorization at any time by sending a signed notice stating my desire to revoke it to Sydney Isley, DBA Chino Valley Therapist. The authorization will cease on the date my valid revocation request is received by Ms. Isley. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall expire on:

Patient or Patient Representative*: Date:

*If signed by a Patient Representative, please indicate the relationship between the Patient and the Patient Representative: