D A V I D M I C H A L I C E K, M. A.
Licensed Marriage and Family Therapist (MFC 52870)

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

Client Name ____

Parent/Guardian Name (if applicable)____

I hereby authorize David Michalicek to release information and receive information regarding my or my child's condition and the progress of treatment with the provider below. I am hereby waiving any claim or privilege of confidentiality between these parties:

Third Party (Doctor, Family Member, etc.) Information

Third Party Name and Title:____

Provider Address:____

Provider Phone: ____

Purpose of release and/or any limitations: ______________________________________

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This release is effective from: _______________ to*: ________________

* If required for length of treatment, indicate to "end of treatment"

I have read the above release agreement. I am the client or the custodial parent/legal guardian of the child in treatment.

Signature ____ Date __________________
Client or Parent/Guardian

Note: The person signing this authorization form has a right to receive a copy of this form as well as to revoke this authorization at any time by informing David Michalicek and the named third party in writing.

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P H O N E : (4 0 8) 6 2 8 – 9 1 7 9