Kimberly Shannon, M.A.
Marriage & Family Therapist

AUTHORIZATION FOR RELEASE OF CLIENT/PATIENT INFORMATION

I hereby authorize the exchange of information between _____and _____regarding _____.

I give permission to exchange the following information:

____ Education	____ Psychological
____ Medical	____ Psychometric
____ Psychiatric	____ Social
____ Legal	____ Progress in treatment

I understand this authorization is valid for six months from the date listed below. I also understand this information may not be released to any other person or organizations without my permission in writing. A photocopy of this authorization shall be considered valid.

Information Regarding _____

Birth Date _____

Relationship _____

Printed Name _____

Signature _____ Date _____

Witness _____

18525 Sutter Blvd., Ste. 200, Morgan Hill, CA 95037-2899
Voice: (408) 776-1009 . Fax: (408) 776-1012
info@kimberlyshannon.com License # MFC23791