Shelby Riley, LMFT and Associates, LLC

Marriage and Family Specialists

223 Byers Road, St 7
Chester Springs, PA, 19425

Authorization to Release Confidential Information

I, (Name of Client) _____, hereby authorize _____**,** to release confidential information during the course of my treatment to the following individual(s), agencies, and/or entities. If the client is a minor, then I am the minor's lawful representative. The purpose of this release of information is to either obtain or provide information regarding the above listed client that is necessary and related to providing professional therapeutic services. The communication may be either written or verbal.

Please write the name, affiliation, and phone number of the person, agency, or entity to be contacted along with specific purposes, uses, and limits on the types of information to released.

I understand that I have a right to receive a copy of this Authorization and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____(Expiration Date)

Signed:_____ Date: _____