Authorization for Client Communication Regarding Confidential Information

Client Name _____ Date of Birth____/____/_____

I, _____ hereby authorize the release of confidential medical information by (*therapist name*) _____ for the purpose of communicating with me about dates of treatment, treatment plans and recommendations, discharge plans, presenting symptoms, and progress to date. I authorize these communications to be sent by email and/or text message to the following email address and/or phone number:

Phone number: _____

Email: _____

This Authorization becomes effective on the date signed and will remain valid until January 1, 2022. I understand that email and text messaging are not confidential or secure forms of communication. A photocopy of this authorization shall be considered valid. I understand that I have a right to receive a copy of this Authorization. I also understand that any cancellation or modification of this authorization must be made in writing and delivered to my therapist directly or to the CIFT office located at 1633 E. Fourth Street, Suite 120, Santa Ana, CA 92701.

By: _____ Date _____
(Client or Client's Representative*)

**If signed by other than Client, please indicate the relationship between Client and his/her Representative:* _____