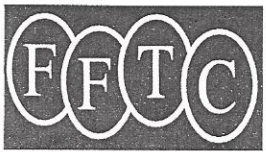

Franconia Family Therapy Center

AUTHORIZATION TO RELEASE INFORMATION

Name of Client: _____

Name of Therapist: _____

As the person signing this authorization form, I understand that the Franconia Family Therapy Center (FFTC) can in no way condition my treatment or payment based upon my willingness to sign this form. I also understand I have the right to not sign this authorization. Therefore, I am giving my permission for the above-named Therapist to disclose personal health record information obtained in the course of my therapy to:

Person: _____

_____

Address: _____

_____

Phone No. _____

Disclosure of this information is for the following purpose: _____

The types of information to be discussed and/or disclosed are as follows: _____

_____

I understand that a copy of this authorization and a notation concerning the person or agency to whom disclosure was made shall be put into my original health record. I also understand that I have the right to revoke this authorization at any time, but that my revocation must be in writing, addressed to the above-named Therapist, and delivered to the address at the bottom of this form. I understand that my revocation is not effective until delivered in writing and is not effective as to the information already disclosed under this authorization.

I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of FFTC.

This authorization expires on the (date) or (event)_____

_____ _____

Signature of Client or Client's Legal Representative — Date

If applicable, what is the relationship or authority of Client's legal representative?

_____

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