

Dr. DeMarquis Clarke, LMFT

1789 South Braddock Ave., Suite 355, Pittsburgh, PA 15218

www.DeMarquisClarke.com

DeMarquisClarke@gmail.com

Office phone number: 412-301-5221

Fax phone number 412-376-5300

Authorization for Release/Exchange of Information

This form provides Dr. DeMarquis Clarke, LMFT with written permission to communicate with other individuals regarding your treatment (i.e. previous therapist, current health care provider, etc.).

I, _____, authorize Dr. DeMarquis Clarke, LMFT to release and/or exchange information about my therapy services with the following party:

Name/Relation: _____

Address: _____

Telephone Number: _____

Information to be Released or Exchanged (checked all that apply)

____ Intake and history ____ Diagnosis and Treatment Plan ____ Verbal Consultation

____ Treatment Progress ____ Discharge Summary ____ Billing and Payment

____ Other (specify): _____ ____ All of the above

This release shall be valid until the termination of treatment or until withdrawn in writing by the client during the course of treatment.

Client Name (please print): _____

Client Signature: _____

Parent Signature (if under 18): _____

Date: _____