**AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS**

**Lisa Hoffort, Psy.D.** **CEDS**

Lic. #: PSY21572

595 East Colorado Blvd, Suite 610

Pasadena, Ca. 91101

I authorized Dr. Hoffort to discuss (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation with any person/s or staff of clinic, office, agency, or institution/s named below and receive any relevant information from them. I understand that when I sign a release of information for Dr Lisa to talk to other members of my treatment team, that honesty and openness between the team members is in my best interest. If I request that specific information be withheld from another treatment team member, Dr Lisa will have the option of discontinuing my therapy due to the limitation of not being able to honestly communicate with another treatment person.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For the following reason(s):

\_\_\_\_ Consultation/Psychotherapy,

\_\_\_\_ Evaluation,

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies form.

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Name (print) Date Signature

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Name of Clinician (print) Date Signature