Cybil Streett
SPORTS PSYCHOLOGY

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____("Patient") hereby authorize Cybil Streett, LMFT to release confidential information obtained during the course of my treatment to _____ ("Recipient").

This Authorization permits the release of the following information:

___ Diagnosis Treatment Plan

___ Progress to Date

___ Prognosis

___ Clinical Test Results

___ Dates of Treatment

___ Any and All Information Necessary

___ Other (specify) _____

I authorize the release of the information described above for the following purpose(s):

The specific uses and limitations on the types of information to be released are as follows:

The specific uses and limitations on the use of the information by Recipient are as follows:

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")

By: _____(Patient or Patient's Representative)

Date: _____

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