Holly Lien, LMFT	*1736 Picasso Ave., Ste A*
Licensed Marriage and Family Therapist	*Davis, CA 95618*
MFC35076	*530-220-3433*
	holly@hollylien.com

Authorization for Release of Mental Health Information

I, _______________________, date of birth _____________authorize Holly Lien, LMFT, to engage in a mutual exchange of information with:

Name: __________________________ Organization: _________________________________

Phone: ____________________________ Address: ______________________________________

Specific nature of information to be released:

Any and all information related to mental health treatment for the purpose of collaborating and enhancing services and care which may include the following:

Assessment of Overall Functioning/Focus of therapy   Response to

Treatment Plan/Goals   Diagnosis/Prognosis

I acknowledge I can revoke this authorization at any time; however, this will not cancel any action that has already been taken. I agree to submit in writing my request to revoke this authorization including the date this is to take effect.

This authorization will remain in effect for one year from the date of signing or until _____________(date).

Client Name: ________________ Client Signature: __________________________Date:______________