

**David Levingston, M.A., LMFT**  
*Licensed Marriage and Family Therapist LMFT 100-0000054*  
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**Consent to Release Confidential Information**

*[If you wish to grant permission for therapist to share any info with a 3rd party]*

I, (Client name) \_\_\_\_\_, D.O.B. \_\_\_\_\_

do hereby authorize:

David Levingston, M.A., LMFT,

to receive from, release to, or exchange with:

\_\_\_\_\_  
Name/Agency

\_\_\_\_\_  
Address/Phone Number

The following information:

*Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.*

For the purpose of:

Client Initial (Check all that apply):

- \_\_\_\_\_  The development of a treatment / service plan  
\_\_\_\_\_  Coordination of care w/ family/behavioral health or medical providers  
\_\_\_\_\_  Ongoing treatment / continuing care  
\_\_\_\_\_  Insurance or employment  
\_\_\_\_\_  Other (Specify): \_\_\_\_\_

I understand that information disclosed above is protected by Federal Regulation 42CFR, Part 2, and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services. I choose to do so willingly and voluntarily for the purposes specified above. The duration of this authorization is no longer than one year unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying David Levingston in writing, except to the extent that action has been taken in good faith on my consent.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian/Legal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

THIS CONSENT WILL AUTOMATICALLY EXPIRE IN ONE YEAR or as specified \_\_\_\_\_