Mallory D. Hepp, LCSW
5535 Balboa Blvd. Suite 206 Encino, CA 91316
Phone: 818-938-1937

Consent to Release Information - Family

I, _____, hereby authorize Mallory D. Hepp
Client Name – Printed

and the party delineated below to disclose and/or obtain information and/or records regarding my diagnosis and treatment and other pertinent information. I realize that the exchange of information between all parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care.

Father: Name_____
Address_____
Phone_____
Fax_____

Mother: Name_____
Address_____
Phone_____
Fax_____

Spouse: Name_____
Address_____
Phone_____
Fax_____

Other: (Relationship _____)
Name_____
Address_____
Phone_____
Fax_____

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: ***Consent Expires on (Date: _____). If no date is specified then the release is valid for one year from the date below. If a client wishes to revoke their consent they should speak directly to therapist.***

_____ _____
Client or Legal Representative Signature Date

_____ _____
Therapist Signature Date