Thomas Kessler, LMFT, RAS CA 51868
1036 Sir Francis Drake Blvd
Kentfield, CA 94904
415-454-8931

CONSENT FOR BILATERAL RELEASE OF CONFIDENTIAL INFORMATION

This form to be filled out by child's authorized representative (i.e. Parent, guardian, social worker, attorney).

Childs Name:_____ Date of Birth: _____

I,_____authorize the two parties listed below to release to each other confidential information about my child, including but not limited to history, functioning, symptoms, diagnoses, treatment interventions and responses, etc. I understand that the purpose of this exchange of information is generally assessment, treatment planning and/or case coordination with other providers. I give my permission for additional purposes listed below.

The authorized parties are:

Name: Thomas Kessler, M.S., MFT, RAS
Professional Designation: Psychotherapist,
Address: 1036 Sir Francis Drake Blvd., Kentfield, CA 94904
Phone Number: 415-454-8931
Email: Marintherapist@gmail.com

Name:
Phone:
Address

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.

This authorization shall remain valid from one year from date of signing unless revoked in writing earlier or renewed.

A fax or photocopy of this release is to be considered as valid as the original.

Signature:_____Date:_____

Relationship to child: _____

Copy given to: ___Client___Parent ____Other party ___Client's representatives