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**CONSENT FOR RELEASE OF INFORMATION**

I/WE, \_\_\_\_\_, authorize

Judith Mathews MFT to mutually exchange information with

\_\_\_\_\_  
\_\_\_\_\_

regarding \_\_\_\_\_

\_\_\_\_\_.

This release of confidentiality applies only to the information noted above. Unless expressly revoked, this consent expires one year after the date of signature.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL AND STATE REGULATIONS (NRS 42 CFR) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE WITHOUT THE EXPRESS WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR UNLESS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION OF THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

\_\_\_\_\_  
CLIENT DATE

\_\_\_\_\_  
PARENT/GUARDIAN (WHERE APPLICABLE) DATE

\_\_\_\_\_  
WITNESS/THERAPIST DATE