**Victoria Curea, Psy.D., MFT Lic. # MFC41124**
***Dr. Victoria Curea – Marriage and Family Therapist, Inc.***
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# RELEASE OF INFORMATION

I, _____, hereby authorize Victoria Curea, Psy.D, MFT, to release confidential information obtained during the course of my treatment with the person named here: _____.

Their contact information is: (Phone) _____ (Email) _____.

This authorization permits the release and exchange of the following information:

- ❍ Any and all information necessary
- ❍ Treatment Planning
- ❍ Professional Consultation
- ❍ Summary of Treatment
- ❍ Confirmation of Treatment (Treatment Dates, Number of Sessions)
- ❍ Psychological Testing
- ❍ Psychological Evaluation and Treatment
- ❍ In Conjunction with a Medical Evaluation
- ❍ Request for Payment/Billing Information/Financial records associated with the above named client
- ❍ Other _____

I understand Victoria Curea, Psy.D, MFT, will release information pertinent to my case with the above named individual or agency. Dr. Curea will make every effort to release only that information deemed necessary for the purpose(s) given above. I also understand I have a right to receive a copy of this authorization. Any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid for ❍ **six (6) months** or ❍ **one year (12) months** from date of signature.

_____
Client/Patient Name (Printed)*

_____
Date

_____
Client Signature*

* If signed by someone other than client, (defined as person in treatment) please indicate the relationship between the client and his/her/their representative:
_____