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Consent for Bilateral Release of Confidential Information

Client Name

Client DOB

I, _____, authorize the two parties (#1 & #2) listed below to release to each other confidential information about me, including but not limited to:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Historical information | <input type="checkbox"/> Attendance | <input type="checkbox"/> Participation | <input type="checkbox"/> Cooperation |
| <input type="checkbox"/> Recommendations | <input type="checkbox"/> Session topics | <input type="checkbox"/> Progress | <input type="checkbox"/> Current status |
| <input type="checkbox"/> Summary of treatment | <input type="checkbox"/> Other _____ | | |

The purpose of this release is:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Obtain information only | <input type="checkbox"/> Progress reporting | <input type="checkbox"/> Case updates |
| <input type="checkbox"/> Other _____ | | |

These parties are:

1. Name: Tiffany C. Shanks, MA, LMFT
Licensed Marriage Family Therapist #84490

2. Name: _____

Professional Designation: _____

Address: _____

Phone: _____ FAX: _____

This consent shall be valid from _____ to _____

I, the aforementioned, understand that I may revoke this release, in writing, at any time, except to the extent that it has already been acted upon.

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

(Date) (Signature of Client) (Client Printed Name)

- Copy/FAX given to: Client Parent Guardian Other Party _____
 CSW Representative
 Original retained by therapist in client file

Please remember that a Release of Information is not needed in situations that involve mandatory reporting.