

Melinda Carlisle, M.A
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Authorization for Release of Information

I, _____ hereby authorize Melinda Carlisle, LMFT (Licensed Marriage and Family Therapist), to release the clinical records and information pertaining to my mental health history, treatment and services rendered to _____.

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Melinda Carlisle, LMFT unless I request otherwise. I may withdraw this consent in writing at any time. If I withdraw, I understand that Melinda Carlisle may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I also agree to pay any fees, if applicable, associated with copying, reviewing, and mailing of records.

Signature: _____ Date: _____
Printed Name: _____

Additional Release of Information

Complete to allow your other providers to consult with me if applicable

In addition, authorize _____ to release clinical records and information pertaining to my mental health history, treatment and services rendered to Melinda Carlisle, LMFT.

Signature: _____ Date: _____
Printed Name: _____

Melinda Carlisle, LMFT

Release of Information