Miyoung Son. M.A

Licensed Marriage & Family Therapist #97293

AGREEMENT FOR EXCHANGE AND/OR RELEASE OF INFORMATION

I (we) hereby authorize Miyoung Son, LMFT to exchange and/or release clinical information with the individual or agency listed below.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

This agreement shall be valid from: _____ to _____

Miyoung Son will observe applicable rules of confidentiality regarding any information, written or verbal, that is received under this agreement. It is understood that this exchange and/ or receipt of information is intended solely for the purpose of furthering treatment. A photocopy of this authorization shall be considered as effective and valid as the original and I understand I have a right to receive a copy of this document.

_____	_____	_____
Client Name Print	Signature	Date

_____	_____	_____
Client Name Print	Signature	Date