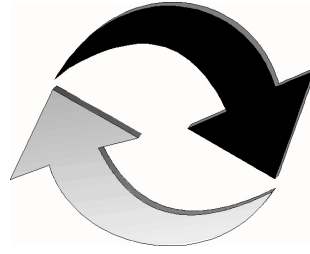


**David Hammer, M.F.T.**  
*Individual and Family Therapy*  
license # MFC 22942



1845 Iron Point Road, #180  
Folsom, CA 95630  
**(916) 966-7300**

AUTHORIZATION FOR RELEASE OF  
CONFIDENTIAL INFORMATION

re:

Dear Colleague:

Your current or former patient named above has been in outpatient psychotherapy treatment with me. To facilitate treatment, the patient has signed the authorization below so we may exchange information. I would like your assistance as indicated:

- Summary of patient history, diagnosis and treatment.  Progress records.
- Entire psychotherapy record, including Psychotherapy notes.
- I will be telephoning to discuss clinical impressions.

The patient and I thank you for your cooperation and concern.

I, \_\_\_\_\_ request that David Hammer exchange information with the following person or his representative:

\_\_\_\_\_ to exchange the following information:

- \_\_\_ Any and All Information Deemed Necessary
- \_\_\_ Diagnosis \_\_\_ Treatment Plan \_\_\_ Prognosis
- \_\_\_ Progress to Date \_\_\_ Clinical Test Results \_\_\_ Dates of Treatment
- \_\_\_ Patient Records \_\_\_ Summary of Treatment
- \_\_\_ Other (describe:)

This information will be used for:

- Providing the highest quality treatment;
- Acknowledging the referral and commencement of treatment;
- Third party payor claim processing or review;
- Proof that legal mandates upon the client have been fulfilled;
- Other:

This consent may be revoked by me in writing at any time, and unless revoked earlier, expires \_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_