Carolyn Mehlomakulu, LMFT-S, ATR
13706 Research Blvd, Ste 114, Austin, TX 78750
Phone: (512) 660-7279 Fax: (888) 972-5053
Email: therapywithcarolyn@gmail.com

CONSENT TO RELEASE & REQUEST CONFIDENTIAL INFORMATION

Client:________________________________ D.O.B.____________________

I (client/guardian) ____________________________________ hereby authorize Carolyn Mehlomakulu, LMFT-S (#201229), ATR (#12-188) to exchange confidential information regarding treatment with:

Contact Name & Relationship: ____

Address:____

Phone, Fax, Email: ____

Information to be disclosed:

☐ Diagnosis ☐ Treatment Plan

☐ Assessment ☐ Other: ________________________________

Purpose of this disclosure: ____

____

____

This authorization is in effect from ________________ to ______________, not to last more than one year. I understand that I may cancel or modify this authorization in writing prior to the expiration date. I understand that I have a right to receive a copy of this authorization.

____ ________________
Client Signature Date

____ ________________
Parent/Guardian/Conservator Signature Date

____ ________________
Therapist Signature Date