

Nicole Ashton, M.A., MFT, CSAT, CCPS
Certified Sex Addiction Therapist
Certified Clinical Partner Specialist
Licensed Marriage and Family Therapist MFC# 45884
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Authorization to Release Confidential Information

I, _____, am currently a client of Nicole Ashton, MA., MFC #45884 and hereby authorize and willingly give my consent to _____ to release confidential information obtained during the course of my treatment to Nicole Ashton, MFT

This Authorization permits the release of the following information:

- Any and All Information Necessary
- Diagnosis Treatment Plan Prognosis
- Progress to Date Clinical Test Results Dates of Treatment
- Patient Records Summary of Treatment
- Other

I authorize the release of the information described above for the following purpose(s):

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid for one year from the date indicated below.

Patient Signature

Date

(Patient or Patient's Representative*)

Date

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: