Hillary Dupuis, MA, LMFT
Psychotherapist
License No. 52412
www.hillarydupuismft.com

Release of Information

Name of client: _____ **Date of Birth:** _____

I authorize Hillary Dupuis, MFT, to disclose information obtained in the course of treatment for the purpose of facilitating treatment and shall be limited to the following types of information. I recognize that if I am disclosing my information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law requires that recipients refrain from redisclosing such information except with my written authorization or as specifically required by law.

- ☐ Assessment
- ☐ Treatment Plan of Care
- ☐ Mental Health Diagnosis
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Results of Psychological Testing
- ☐ Educational Assessment and Behavioral Reports (includes school observation and educational testing)
- ☐ Substance Abuse Treatment
- ☐ Other: _____

Send to: _____
(Name, title & address of person or organization authorized to receive the information.)

Client Rights: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to Hillary Dupuis, MFT, 1350 Hayes Street, Suite B12cc, Benicia, CA 94510. My revocation will be effective upon receipt. I have the right to obtain a copy of this authorization.

_____ _____
Date Client Signature