The Canine Cure℠

William Benson, L.M.F.T.
License # MFC 37686

7985 Santa Monica Blvd. Suite 207
West Hollywood, California 90046

www.thecaninecure.com
(310) 849-9399

Authorization to Release Confidential Information

I, _____("Patient") hereby authorize William Benson, LMFT and/or Employees of The Canine Cure ("Practice") to release confidential information obtained during the course of my treatment to_____("Recipient").

For the purposes of_____.

This Authorization permits the release of the following information:

___ Any & All information Necessary
___ Progress to Date
___ Clinical Test Results
___ Diagnosis
___ Treatment Plan
___ Prognosis
___ Dates of Treatment
___ Other (Specify:_____).

Name of Recipient(s):

Address: City/State/Zip:

Phone: Secure Email:

Patient understands that s/he has a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing. The uses and limitations on the use of the information by Recipient are to be negotiated between the Patient and Recipient. Practitioner and/or Practice shall abide by the terms of this contract only. Patient understands that Practitioner is a Mandated Reporter: If Practitioner deems a Patient-induced situation is dangerous to the Patient or others, Practitioner has the legal duty to breach confidentiality in order to help insure the safety of all concerned.

This Authorization shall remain valid until: _____("Expiration Date")

By: Date:

(Patient or Patient's Representative)