CONFIDENTIAL CLINICAL INFORMATION

KAREN FLYNN, M.F.T.
PSYCHOTHERAPY
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Phone: 510 316 5951

CONSENT FOR EXCHANGE OF CLINICAL INFORMATION

I, _____ give permission for **KAREN FLYNN, MFT**
Name of patient or parent/guardian of minor patient

to exchange clinical and educational information regarding: _____
name of patient (self or child)

with (name, relationship, phone #):

_____

_____

_____

_____

This consent provides for the exchange of oral and/or written information, including psychiatric, chemical dependency, educational, and medical information and is limited to clinical information necessary to provide good clinical care.

This consent shall expire one year from the date of signature. I understand that I may rescind this consent at any time with a written request to Karen Flynn, stating that I do not give permission for further release or exchange of information.

I have carefully read, and I understand, the foregoing. I consent to the release of the above-specified information. I release Karen Flynn from any liability arising from the release of this information to designated persons or agencies.

Date: _____ _____
Signature of patient or parent/guardian

I hereby certify that it is my opinion that said patient (parent/guardian) understands the nature of this release of information and is competent to give informed consent.

Date: _____ _____
Karen Flynn, M.F.T.