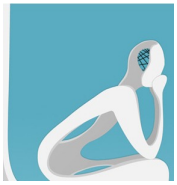
Jon B. Pease, MA, LMFT
MFC 48823



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Authorization to Release Confidential Information

I, [Name of Client/Guardian] _____ hereby authorize Jon B. Pease, MA. LMFT to release confidential information obtained for myself child family (circle one) during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] _____ ("Recipient").

This Authorization permits the release of the following information:

_____ Any/All Information Necessary	___ Diagnosis	___ Treatment Plan
____ Progress to Date	____ Prognosis	____ Clinical Test Results
____ Dates of Treatment	____ Other (specify)	

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

The specific uses and limitations on the types of information to be released are as follows: _____

The specific uses and limitations on the use of the information by Recipient are as follows: _____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

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

By: _____Date: _____
(Patient or Client's Representative)

By: _____Date: _____

(Patient or Client's Representative)