

Release of Information Form

James J. Sanders, LMFT, LPC, CCMHC
Licensed Marriage and Family Therapist, Lic. #40061
Cell (949) 636-7529
Fax (949)706-6498
www.SandersTherapy.com
James@SandersTherapy.com

I _____,
Client/Parent/Guardian (please circle)

Authorize James J. Sanders, LMFT, to release/obtain information to/from:

This information is for the sole purpose of continuity of professional care for

I understand I can revoke this authorization at any time
with written notice to James J. Sanders, LMFT

Signature: _____ Date _____

Signature: _____ Date _____