Heidi Pidcoke, MFC 38701
heidi@heidpidcoke.com
(626) 716-4850

RELEASE OF INFORMATION

Client's Name(s): ____

Address: ____

Client's Date of Birth: ____

I/(We), ______________________________________authorize Heidi Pidcoke, MA, LMFT to exchange confidential information regarding my treatment with:

Name: ____

Address: ____

Phone: ____

Email: ____

Information needed by (date) ___ / ___ / _____ (optional)

Please indicate one way or two-way exchange of information.

☐ One Way (Information from above listed parties to Heidi Pidcoke)
☐ Two Way (Information to and from Heidi Pidcoke and the above listed parties)

This Authorization permits the exchange of:
☐ Any and all information relevant to my treatment
☐ Only the following information (check all that apply):

☐ Psychological/Psychiatric Evaluations
☐ Attendance and Progress in Therapy
☐ All of the above

Exceptions:____

This consent of disclosure will expire 6 months from the date of signature.

Client Signature (or Parent/Guardian Signature)______________________________
Date____