Britt Brennan
Marriage and Family Therapist
M.A. | LMFT

Information Release

I, _____, hereby authorize my therapist, Britt Brennan, MA LMFT, to exchange confidential information regarding my treatment with _____.

This authorization permits the exchange of the following information:

- ☐ Any and All Information Necessary

☐ Diagnosis	☐ Treatment Plan	☐ Prognosis
☐ Progress to Date	☐ Clinical Test Results	☐ Dates of Treatment
☐ Client Records	☐ Summary of Treatment	☐ Other

I understand that I have a right to receive a copy of this authorization.

I also understand that any cancellation or modification of this authorization must be in writing.

_____ _____/_____/_____
Client Signature Date

_____ _____/_____/_____
Britt Brennan MA, LMFT Date

15215 S. 48th Street Suite 116 | Phoenix, AZ 85044
Office Phone: 480.200.5752