Mark Tinley, MA, LMFT
Marriage & Family Therapist - License # 52487 California, USA
Room A, 7/F, Duke Wellington House
14-24 Wellington Street, Central, Hong Kong
+852 9315 2151   Mark@sCounselling.com   sCounselling.com

Authorization to Release Confidential Information

By signing this document, I, ____ ,
hereby authorize Mark Tinley, Marriage & Family Therapist, to disclose information and/or records obtained in the course of my treatment to:

______________________________________, ______________________________
(Name of Receiving Party)   (Function)

Address: ____ Phone: ______________

I understand that I have a right to receive a copy of this authorization. I also understand that I have a right to cancel this authorization, but that any cancellation or modification of this authorization must be in writing. This disclosure of information or records authorized herein is required for the following purpose:

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Such disclosure shall be limited to the following specific types of information:

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This authorization shall remain valid until: ________________________________

____
Signature(s)

____ __________________
Signature(s)   Date

Form Rev. Nov 6 2017