Heather Fabbre LMFT
Licensed Marriage Family Therapist
Registered Art Therapist

Authorization to Disclose Protected Health Information

I, __________________________, hereby authorize Heather Fabbre, LMFT ("Provider") to disclose to _____________________________________ ("Recipient"). Working collaboratively will provide continuity in treatment which will benefit the therapeutic process.

Recipient phone number____________________________________
Fax number ____
Mailing Address: ____
____

I authorize the disclosure of the health information described above for the following purpose:
____
____.
The specific limitations are as follows:
____
____.
By: ______________________________ Date: _________________________________

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