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510-527-1501

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____,hereby

authorize and request that

Laura Soble, MA, MFT, REAT

may release and/or receive confidential professional information

pertaining to me (or my minor child ________________________) to and/or from

Name:

Phone:

Fax:

Address:

I understand that I may revoke this consent at any time by
informing the above parties in writing.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Client: Date:

and/or

Parent/Guardian: Date: