

## Agreement for Exchange and/or Release of Information

I (We) hereby authorize an exchange and/or release of clinical information between

**KEITH RAND, MFT CGP**

California license #MFC 32393

and

\_\_\_\_\_  
name of therapist, psychiatrist, social worker, or agency

\_\_\_\_\_  
address

\_\_\_\_\_  
phone number

Keith Rand, MFT guarantees that he will observe the rules of confidentiality regarding any information, written or verbal, that is received under this agreement. It is understood that this exchange and/or receipt of information is intended solely for the purpose of furthering treatment.

A photocopy of this authorization shall be considered as effective and valid as the original and I understand that I have the right to receive a copy of this document. I also understand that I may revoke or modify this authorization in writing at any time.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date signed

*Unless otherwise stated, this release shall remain in effect for one year from the date signed and can be renewed upon request.*

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