Ruthanne Iliff, M.A., LMFT, BCN
12401 Wilshire Blvd, Ste 300
Los Angeles, CA 90025
818.669.0207

Authorization to Release Confidential Information

I, _____ agree to allow the following release and exchange of information:

Ruthanne Iliff, LMFT

With_____.

This is for the purpose of :

Continuing treatment _____

Assessment/evaluation _____

Neurofeedback assessment _____

Other, please specify _____

Signature: _____

Date: _____

Note: This authorization is to expire one year from the date of signature>