



# Diane Gleim

Licensed Marriage and Family Therapist  
AASECT Certified Sex Therapist & Supervisor  
IAPST Certified Psychosexual Therapist™ & Supervisor  
LIC# MFC44429

## Authorization to Disclose Confidential and Protected Health Information

I hereby authorize Diane Gleim, MFT to disclose the following mental health treatment information:

- |   |   |
|---|---|
| <input type="checkbox"/> Evaluations/Assessments  | <input type="checkbox"/> Medication Evaluations |
| <input type="checkbox"/> Drug/Alcohol Information | <input type="checkbox"/> HIV Status             |
| <input type="checkbox"/> Clinical Test Results    | <input type="checkbox"/> Dates of Treatment     |
| <input type="checkbox"/> Psychotherapy Notes      | <input type="checkbox"/> Entire File            |

TO:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

The disclosure of information is requested for the purpose of: \_\_\_\_\_

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Diane Gleim, MFT has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Diane Gleim, MFT to be effective. I understand that Diane Gleim, MFT cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

This authorization will remain in effect for 1 year unless otherwise stipulated below:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_


Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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