AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Re:_____Date of Birth_____

This is to authorize_____

_____

Address City State Zip

To disclose and release any information, including psychiatric and psychological records, for the individuals named above to_____, who is authorized to discuss all matters pertinent to the progress of the client.

This information is considered instrumental to the ongoing evaluation and treatment of the client.

Information requested:_____
_____
_____

_____Date_____
Client Authorization

This authorization for release is valid for the period of one year from the above date.