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Authorization for Release of Information

Client Name: _____

Authorization: I hereby authorize

Name of Professional/Organization: _____

Address: _____

Telephone: _____ Fax: _____

to release psychological, social, and or medical information from the records of the above identified client to:

Name of Professional/Organization: _____

Address: _____

Telephone: _____ Fax: _____

Description of Information Requested:

Reason for this request:

Client Signature

Witness

Parent or Legal Guardian

Date

This authorization is valid for 90 days and can be revoked in writing at any time.