AUTHORIZATION TO REQUEST/RELEASE INFORMATION

I, _____, authorize Alex Fuller MA, LPC to request/release information concerning me from/to:

_____

_____

Items and information to be released are:

_____

_____.

I understand that I may revoke this authorization to release information at any time by giving written notice to my therapist. I also understand that any information released prior to my revoking this authorization, shall not be a breach of my right to confidentiality.

Specific information to be excluded from release (if no exclusions, leave blank):

_____

_____

Unless otherwise indicated, this release will expire 1 year from the date listed below.

_____

Signature of Client Date

_____

Signature of Parent/Guardian Date

Alexander Fuller MA, LPC
608 Main St, Louisville CO 80027
720 352 3594