A FAMILY WORKS, COUNSELING PLLC

1760 E Boston Street, Suite 102
Gilbert, AZ 85295
(480) 649-6499

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client: ____ Date of Birth: ____________

I, ____ hereby authorize A Family Works, Counseling PLLC, and the agency or individual named below to release to each other any or all medical, psychological, or educational information they may have pertaining to my case or to the case of the client named above:

Person or Agency: ____

Address: ____

Phone: ____

I understand that I may revoke this authorization at any time, except to the extent to which action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it is signed.

Client Name ____ Date _____________

Client Signature____ Date _____________

Parent/Guardian ____ Date _____________

Witness Signature ____ Date _____________