Authorization to Release Information Form

Client Full Name:

Date of Birth:

Address:

I authorize the release of my information to:

Organization/Individual Name:

Phone/Fax/E-mail:

Address:

Type of Information to be Released:

Purpose of Disclosure:

I understand that this authorization is voluntary and I may revoke it at any time in writing. Unless otherwise revoked, this authorization will expire on:

Client Signature:

Date:

Witness/Guardian Signature (if required):

Date: