

Louis Carlino, MA
1911 11th Street
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Boulder, CO 80302
(303) 815-0898

Authorization to Request or Release Confidential Client Information

1. Client Name: _____
2. I am ___ the client
___ the person legally responsible for the above-named client

3. I authorize **Louis Carlino, MA** to
___ obtain information from
___ release information to:

Facility/Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____ Fax: _____

4. Specific information to be released or obtained:

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

This information will be used to promote counseling. I understand that I may revoke this authorization at any time by giving written notice to Louis Carlino, MA. Unless I revoke this authorization prior to such time, this authorization to release/obtain information shall expire one year from the date of my signature.

Print Client Name

Client Signature (legal guardian if under 16 years of age)

Date

Therapist Signature

Date