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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, LPC** 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, RYT. 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