AUTHORIZATION FOR RELEASE OF INFORMATION

I/We _____ hereby give permission to

_____

(Medical Provider / Person / Institution)

Address: _____

_____

Phone: _____ Email: _____

TO RELEASE AND RECEIVE INFORMATION TO AND FROM

Gina Candelaria, M.Ed., M.C., LPC
8115 E. Indian Bend Rd, Ste 119 Scottsdale, AZ 85250
480 332 7383
Email: counseling@ginacandelaria.com

The following information:

__ Diagnostic/Assessment __Treatment Plan __Treatment Summaries
__ Treatment Recommendation __Expected Length of Treatment
__Other, (specify) _____

For the purpose of _____

Date of this Release: _____ to _____

I understand and agree that no legal responsibility or liability of any nature shall attach to the attending therapist in acting upon this authorization and request. I understand that I may revoke this authorization at any time and must do so in writing. If I do not revoke it, this consent will expire one year after closure of therapy.

Client: _____ Date of Birth: _____

Signed: _____ Date: _____