AUTHORIZATION TO RELEASE CONFIDENTIAL AND PRIVILEGED INFORMATION

I authorize Karla Campbell, MA, LMHC to release/request the information described below to:

_____
Name

_____
Mailing address

_____
City, State, Zip

_____
Phone

Purpose or need for this disclosure:

_____

_____

Information I specifically authorize to be released:

_____

_____

_____

This authorization shall expire 90 days after this request is signed, unless I inform Karla Campbell, MA in writing that I wish to revoke it at an earlier time. I hereby release Karla Campbell, MA from all legal responsibility or liability that may arise from release of this information. This consent is freely and voluntarily given.

_____ _____
Print Full Name Date

_____ _____
Signature of Client Date

_____ _____
Signature of Parent of Guardian Date

_____ _____
Signature of Witness Date