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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby give permission to Aaron Buckwalter, M.F.T., Licensed Clinical Therapist, to release information to and to receive information from the party described below:

_____
NAME

_____
ORGANIZATION

_____
STREET ADDRESS

_____
CITY, STATE AND ZIP CODE

_____ _____
TELEPHONE NUMBER FACSIMILE NUMBER

I understand that this exchange of information will only pertain to my treatment. I also understand that this Authorization will be considered void immediately upon my request in writing, one year after the date I have signed it or at which time treatment is terminated (whichever shall occur first).

_____ _____
CLIENT'S NAME PRINTED *Date of Birth*

_____ _____
CLIENT'S SIGNATURE *Date*

_____ _____
LEGAL GUARDIAN'S SIGNATURE (IF CLIENT IS A MINOR) *Date*