AUTHORIZATION TO RELEASE INFORMATION

____
Name of Client

____
Date of Birth

____
Social Security #

I understand that the purpose of this release is to assist with my treatment by improving communication between professional service providers at The Center for LifeSpan Development, Inc. and important individual(s) in my life. To further this goal, I authorize

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to release my information to assist in my psychological treatment.

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire within one year of the date of this document or upon conclusion of my services, whichever comes first.

____ ________________________________
Signature of Client / Parent Guardian Date

____
Signature of Witness

THE CENTER FOR LIFESPAN DEVELOPMENT
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