

AUTHORIZATION TO REQUEST/RELEASE INFORMATION

I, _____, authorize Michelle Frieswyk-Johnson to request/release information concerning me from/to _____

Items and information to be released are: _____

I understand that I may revoke this authorization to release information at any time by giving written notice to my therapist. I also understand that any information released prior to my revoking this authorization, shall not be a breach of my right to confidentiality.

Signature of Client

Date

Signature of Parent/Guardian