

Northlight Counseling Associates, Inc.
5050 N. 8th Pl. #8 Phoenix, AZ 85014
Phone 602-285-9696 Fax 602-277-5930

AUTHORIZATION
____ TO RELEASE INFORMATION TO
____ TO REQUEST INFORMATION FROM

I, the undersigned, hereby authorize _____
(Persons name that will release information)

Address and/or Phone and Fax number: _____
(Persons that will release information)

to release information about myself/son/daughter/ward, named

(Clients Name) _____ (D.O.B.)

To _____
(Persons name that will receive information)

Information to be released

[] All information

[] The following information: _____

(Specify information)

1. _____
Signature of client or representative _____ Date

Witness _____ Date

2. _____
Additional Participant _____ Date

3. _____
Additional Participant _____ Date

4. _____
Additional Participant _____ Date

This release is valid until six months from termination of treatment.