AUTHORIZATION FOR RELEASE OF INFORMATION

Fill out this form if you give permission for me to communicate to another individual or agency (attorney, physician, probation officer, spouse, etc.)

Client's Name: _____

Date of Birth:_____

I am authorizing the listed below parties to release or disclose to one another regarding me or my (my child's) case.

Denise DeNicolo, M.S.

18534 Forty-Six Pkwy, Suite 4
Spring Branch, Texas 78070
Phone (210) 865-6445 ~ Fax (866) 838-2089

Name: _____

Address:_____

City, State, Zip: _____

Telephone Number: _____Fax Number: _____

The following items are requested:_____.

This request is made voluntarily for professional psychological purposes. I can revoke this authorization by giving written notice to my health service provider. If not revoked, this form will be valid for one year from the date signed. A photocopy of this authorization will be valid as the original.

_____ _____

Signature (if child, then legal guardian) Date