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Authorization for Release of Information

I hereby authorize the release and exchange of all pertinant medical, psychological, and educational information concerning (client) ____________________________________ between ___________________________________ and Uriah Guilford, MFT for use in assessment, consultation and/or psychotherapy.

This authorization shall be valid until: __________________________

I agree that a photocopy of this authorization shall be as valid as the original, and that I may revoke this release at any time. I have received a copy of this authorization.

Signed _______________________________________ Date _____________________
(Client, Parent, or Gaurdian)

_______________________________________ Date _____________________
(Witness)