Authorization for Release of Information

Client's Name: _____Date of Birth: _____

Address: _____

City: _____State:_____Zip:_____

Social Security #_____

I hereby authorize **Sonja Fulmer, M.A.** to release to and receive from _____ any and all

information except as specified below:

_____

_____

I understand that this information will be used for the following purpose(s):

____ 1. To develop a diagnosis, treatment, and/or rehabilitation plan
____ 2. To coordinate medical, psychological, and social rehabilitation processes
____ 3. Other_____

I understand that no information may be re-disclosed to any other individual or agency without the undersigned's written consent. Further, this authorization may be revoked at any time by written statement from the undersigned and shall be automatically revoked at the end of ____ days or under the following specific conditions:

_____

Signature of Client: _____Date:_____

Parent or Guardian (if client is under 18):

_____Date:_____