AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, grant permission and give authorization for Dr. Myra L. Burgee and staff at Applied Counseling & Psychoeducational Services, PC, to provide information and consultation regarding assessment and/or treatment of _____ to the following professionals:
(self or child's name)

Name: _____ Title: _____

Organization/Company: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Communication Type: ___Written _____Oral ___Both

Type of Communication: ___Phone ___Email ___ Postal Mail ___Fax

++

Name: _____ Title: _____

Organization/Company: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Communication Type: ___Written _____Oral ___Both

Type(s) of Communication: ___Phone ___Email ___ Postal Mail ___Fax ___ALL

By signing this authorization form, Dr. Myra L. Burgee and Applied Counseling & Psychoeducational Services are released from all legal liability with regard to this release of information. You have the right to revoke this authorization at in time in writing.

_____ _____

Signature of Client or Guardian Date