AUTHORIZATION TO RELEASE INFORMATION

Client Name:	DOB:

I hereby authorize _____
(agency and contact person)

located at _____
(address/phone number/fax number)

to *(check all that apply)*:

- ❑ Release the following information to:

Tess Cialdini, LQP, LCSW, LCAS

- ❑ Obtain the following information from Tess Cialdini and hereby authorize Tess to release this information to them.
- ❑ The above person/agency and Tess Cialdini to exchange information with each other on an ongoing basis for the duration of the terms of this release.

This release applies to the following information:

- ❑ Social History
- ❑ Treatment Summary
- ❑ Client Records
- ❑ Other: _____

The purpose of this release is: _____

This information is released with the understanding that it is not to be re-released without my written permission or the written permission of my legally-authorized representative, except as required by law. This authorization is limited to the person, agency, school, or insurance company named above and is not to be used for any other purpose than the one specified.
This release will automatically terminate on _____.

Signed:_____ Date:_____

Signed:_____ Date:_____

Signed:_____ Date:_____

Signed:_____ Date:_____

Therapist Signature:_____ Date:_____