Gary M. Unruh MSW, LCSW
Child and Adolescent Clinic PC
7680 Goddard Street, Suite 205
Colorado Springs, CO 80920

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth _____

I hereby authorize Gary M. Unruh, MSW, LCSW, to release information to or request information from:

_____
Primary Care Physician (please print name)

_____
School Counselor (please print name)

_____
Other (please print name)

I hereby release Gary M. Unruh, MSW, LCSW, and my primary care physician from all liability and all claims of any nature whatsoever pertaining to the disclosure of information contained in my medical records.

Client Signature_____ Date_____
(Parent or guardian signature if client is under the age of 15)

Witness_____ Date_____