Swanson, Conti & Associates

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Authorization To Release Confidential Information

I, ___________________________, do hereby give permission to (Check all that apply:

☐ David Swanson, Psy.D, ☐ Rachela Conti, Psy.D,

☐ Other: _____________________

to release information to and to receive information from the party described below:

____
Name

____
Organization

____
Street Address

____
City, State and Zip Code

_________________ _________________
Telephone Number Facsimile Number

I understand that this authorization will be considered void immediately upon my request in writing, one year after the date I have signed it or at which time treatment is terminated (whichever shall occur first).

____
Client's Name Printed

_______________________________________ ____________
Client's Signature *Date*

_______________________________________ ____________
Legal Guardian's Signature (if client is a minor) *Date*

Confidential