



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,

☐ Robert Robbins, LMFT

☐ James McGurk, Psy.D, LMFT

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