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AUTHORIZATION TO RELEASE INFORMATION

By signing this document, I, (Name of Client) _____,
hereby authorize (Therapist) Ceci Addams _____ to disclose information and
records regarding my diagnosis and/or treatment to (Names and Titles/Functions of the
persons and or entities to whom disclosure is made, and their phone numbers/addresses) _____

I understand that I have a right to receive a copy of this authorization. I also understand
that cancellation or modification of this authorization must be in writing. This disclosure
of information and records authorized herein is required for the following purpose: _____

This disclosure shall be limited to the following specific types of information: _____

This disclosure of information and records authorized herein shall be limited to the
following specific uses: _____

This authorization shall remain valid until (Date) _____

Signature of Client

Date

Printed Name of Client