Cassidy Erickson, LMFT
2095 W 6th Ave Ste 206 Broomfield, CO 80020
Phone 720-515-5227
Cassidy.S.Erickson@gmail.com

Authorization to Release Information

Client Name: _____

Birth Date: _____/_____/_____

Exchange with: _____

_____
(Name and contact information of individual or agency with whom information is to be exchanged)

I, _____, authorize **Cassidy Erickson** and the agency or individual listed above to discuss and/or exchange the following information and/or reports:

- ___ Social History/Intake Summary
- ___ Psychological/Psychiatric Exam
- ___ Educational Testing
- ___ Medical History/Diagnosis
- ___ Treatment Notes
- ___ Hospitalization Records
- ___ Treatment Progress
- __ Other-Specify _____

I hereby release the above named parties from any and all liability for revealing and releasing such information. It is understood that this information, once obtained, is not to be released to any other agency or individual. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization to release information at any time, except to the extent that action has already been taken to comply with it, by giving written notice to **Cassidy Erickson.**

This consent is valid until: _____/_____/_____
Date

_____ _____/_____/_____
Signature of Client, if 15 years of age or older Date

_____ _____/_____/_____
Signature of Person Authorized to act on behalf of the client Date

_____
Relationship to client