



Authorization to Obtain or Release Information

Client Name: _____

I, _____, hereby authorize the following individual or agency:

_____	_____
Printed Name	Relationship to Client
_____	_____
Telephone #	Other

to give, and or receive, information to, and or from Rawers Therapy for use in further treatment per the client's request.

The purpose of this Authorization is to either obtain or provide information regarding the above listed client that may be related to current or past professional services provided by Rawers Therapy staff. The communication may be written or oral.

Information to be requested/provided: _____

*If the client is a minor, then I am the minor's legal representative? Yes ____ / No ____

Approval:

_____	_____	_____
Signature	Printed Name	Date

This authorization shall remain in effect for 12 months from the signature date or until revoked in written by the authorizing party. Copy available upon request.