Authorization for Release of Information

Carol Karkazis, LMFT #83475
3300 Douglas Blvd., Suite 240, Roseville, CA 95661
(916) 672-8533

I, _____, hereby authorize Carol Karkazis, LMFT to:

_____Obtain from: _____

_____

_____ Release to: _____

_____

the following information:

_____ Entire Record

_____ Individual Treatment Plan

_____ Treatment Summary

_____ Coordination of Care

_____ Legal Information

_____ Diagnosis

_____ Telephone Content

The above information may be exchanged orally or in writing. This authorization is given of my own free will and is in effect for one year from the date below. I understand I can revoke this authorization in writing at any time.

_____ _____
Signature of Client (Parent or Guardian if minor) Date

_____ _____
Witness Date