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Authorization to Release Information

Client's Name:_____ Date of Birth:_____
Client's Social Security Number:_____

I hereby authorize JulieAnn Krogel, Ph.D. to (check one): _____ obtain from the following
_____ release to the following

Name:_____

Address:_____
_____
_____

the following documents/information from the records pertaining to services received
_____
_____

Dates of Service: _____

The records are required for the specific purpose of: _____

I understand that my authorization will remain effective from the date of my signature until, _____(date) or 1 year from present and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____
Signature of Client/Client's Legal Parent/Guardian Date

_____ _____
Witness Date