Lori J. Collins, M.S., MFT

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CONSENT TO RELEASE INFORMATION

This is to authorize exchange of information between Lori J. Collins, M.S., MFT and the following individual and/or agency/organization:

Name _____

Address _____

Phone _____ Email _____

Regarding the following client(s):

Name(s) _____

Birthdate(s) _____Phone _____

Address _____Email _____

The disclosure of information/records is required for the following purpose:

_____

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, and shall expire upon completion of treatment unless indicated here:
This consent is in force from _____to _____

Client Signature _____ Date _____

Therapist Signature _____Date _____