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### Authorization for the Release of Information

I, (client name) \_\_\_\_\_ hereby request

and authorize my psychotherapist, D. Skeetz Edinger, MS, LMFT-Associate, to release copies of:

\_\_\_\_\_  
\_\_\_\_\_;

for the following dates of service: \_\_\_\_\_

\_\_\_\_\_;

to: (recipient name and contact information) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_.

The limitations or the exclusions of the information to be disclosed: \_\_\_\_\_

\_\_\_\_\_.

This authorization expires on year from the day this document is dated. The client has the right to revoke this authorization at any time.

Be advised that if the person or entity that receives this information is not a health care provider, an insurance company, or another entity that is covered by federal privacy regulations (HIPAA), then the information described in this authorization could possibly be re-disclosed and would no longer be protected by those regulations.

(signature) \_\_\_\_\_ (date) \_\_\_\_\_

(printed name) \_\_\_\_\_

(witnessed by) \_\_\_\_\_ (date) \_\_\_\_\_

This document expires, \_\_\_\_\_, unless revoked by the client prior to this date.