Authorization to Release Information

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_____ _____
Client Name *Date of Birth*

I hereby authorize Julia A Gladnick (CO MFT #998) to release my information

_____
(Person/Organization)

Purpose for the Disclosure:

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Limits:

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1. I understand that I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to Julie Gladnick, MA, LMFT. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will be valid for the indicated period of time identified above.

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse authorization. I need not sign this form in order to receive treatment from Julie Gladnick. I understand that I may inspect information to be used or disclosed as provided in CFR 164.524. If I have any questions about disclosure of my health information, I can contact Julie Gladnick, or consult with APA standards.

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(Signature of Client or guardian) (Date)

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(Signature of Client or guardian) (Date)