Corissa J. S. Gold, MA, MFA, LPC, ATR
Phone: (303) 570-2723 / Email: cgold32@me.com

**AUTHORIZATION TO REQUEST/RELEASE INFORMATION**

I, ___________________________________, authorize
Corissa J. S. Gold, MA, MFA, LPC, ATR to request/release information concerning me from/to _______________________________________________________.

Items and information to be released are:
___________________________________________________________________
___________________________________________________________________
__________________________________________________________________.

I understand that I may revoke this authorization to release information at any time by giving written notice to my therapist. I also understand that any information released prior to my revoking this authorization, shall not be a breach of my right to confidentiality.

____________________________ _______________________________
Signature of Client Date

____________________________ _______________________________
Signature of Parent/Guardian Date