AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Christine Beasley, MA, MFT to exchange written and verbal information for the purposes of treatment planning and intervention about:

Name of client	Date of birth
Address	Phone#

With the following person/agency/institution:

Name	Phone#
Address	FAX#

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.

Revocation: This authorization is also subjective to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that this information may not lawfully further be used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Client signature	Date
Parent/Guardian's signature	Date
Christine Beasley, MA, MFT	Date