STMC, LLC
Clear Heart Counseling
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AUTHORIZATION FOR RELEASE OF INFORMATION

I,______________________________________ , give my permission to Stuart Malkin with

(Name of client)

Clear Heart Counseling to release/obtain information in the form of written records and/or verbal consultation

with/to/from: ____

(Name of organization or person receiving or providing records)

about my self/my child: ____

(Client's or child's full name)

I understand that this information will be used only for the purpose of:

____.

(Purpose for which records and/or information will be used)

The authorization will be in effect from_________________ until ________________, or for one year unless otherwise rescinded.

I understand that I give my permission for the records and/or information to be obtained from or released to only the person or organization, and for the purpose listed above, and only for the time shown above. I may withdraw my consent at any time in writing, or, if I am physically unable to write, by orally advising Clear Heart Counseling.

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Counselor Signature Date

____

Signature of Client (or Parent/Guardian of Child under 16 years of age) Date