AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Patricia Guzikowski, MA, LPC, NCC of **Freethought Counseling LLC, PMB #260, 5760 S. 108th St., Hales Corners, WI, 53130,** to release and disclose information from the clinical record of:

_____ (_____)
(Name of client/recipient of mental health services) (Date of birth)

and allow such information to be inspected and copied by:

_____
(Facility/Provider)

_____
(Address)

Nature of information to be disclosed: _____
(State specific nature of information to be disclosed)

For the purposes of _____
(State specific purpose of information to be disclosed)

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Patricia Guzikowski, Freethought Counseling LLC. I understand that a revocation is not valid to the extent that Patricia Guzikowski, Freethought Counseling LLC, has acted in reliance on such authorization. This authorization is valid until _____.
(Date)

A copy of this release shall have the same force and effect as the original.

_____
(Client Signature 18 yrs. or older) (Date)

_____ _____
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.