AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I _____ give Gail Nicholson, MA, LPC

permission to ____ release and or ____ receive:

___ information relevant to my treatment

___ mental heath records

___ diagnosis

___ course in treatment

___ consultation

to or from _____, telephone

number _____ to assist in my treatment or for the

purposes of third party payment.

I understand that such information cannot be released without my specific consent, unless I am a threat to myself or others are involved in child or elder abuse, or under specific court order.

Signature: _____ Date: _____

Witness: _____ Date: _____