

AUTHORIZATION FOR RELEASE OF INFORMATION FOR ADULT

I, _____, with my signature below, give authorization for **Antje Rath, CMHC**, to exchange written information and to discuss information relevant to my case with the below-named person or entity:

Name: _____

Address: _____

Telephone: _____

This authorization is valid from the date of authorization until termination of treatment with Antje Rath, CMHC, unless otherwise indicated.

Date

Client signature

Date

Witness Signature