

Authorization For Two-Way Release of Information

I hereby authorize a two-way release of psychological and medical information between

Psychotherapist, Tricia K. Buttkus, LCSW

And _____

(Name and Title)

Re: _____

(Name of Client)

A photocopy of this authorization shall be equivalent to the original.

This authorization can be revoked by me at any time except to the extent that action has been taken in reliance thereon. I understand that such revocation must be in writing and delivered to all the above named professionals. If not earlier revoked by me, this authorization shall automatically terminate one year after treatment has been completed and professional fees have been paid in full.

(Date)

(Birth Date)

(Client Signature)