Fountain City Counseling

Authorization to Obtain or Release Information/Records

Client Name:_____ Case #:_____

Therapist Name –

I hereby authorize – Fountain City Counseling
133 First Street
Prattville, AL. 36067

to consult with or release/obtain records from the following persons for the purpose of enhancing my treatment/consultation:

Name:_____
Address:_____
Phone Number:_____

Name:_____
Address:_____
Phone Number:_____

This authorization begins on the date of my signature and automatically expires in twelve (12) months unless cancellation is requested prior to this date.

Client Signature Date	**Client Signature Date**
Client Signature Date	**Client Signature Date**
Witness Signature Date	**Expiration date**

PLEASE ADDRESS ALL CORRESPONDENCE TO:

Thea Langley, AMFT, MA