Melissa M. Marciano, LMHC,NCC

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize Melissa M. Marciano, LMHC, NCC to release and secure information from:

____
Name

____
Address

____
City/State/Zip

____
Phone

regarding pertinent information relevant to my treatment. The purpose of such disclosure is:

____
____

(example: to aid in patient's treatment; financial purpose, etc)

I understand that this consent can be cancelled by me in writing at any time. Action taken prior to cancellation cannot be revoked.

AUTHORIZATION EXPIRES 1 YEAR FROM SIGNING

____
Client Name

____
Signature Date

____
Witness Date