



LIFE COACHING & COUNSELING CENTERS, LLC

Sarasota, FL

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(Name) (Address)

authorize _____
(Name) (Address)

to disclose to _____
(Name) (Address)

the following information:

for the following purpose:

A copy of this release is as valid as the original.

This authorization may be withdrawn at any time in writing except to the extent that the program or person, which is to make this disclosure, has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. This release of information expires in ____ days following completion or termination of treatment, except for information to be released or exchanged for purposes of a claim for benefits. If for a claim for benefit, this release of information expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

EXECUTED THIS _____ DAY OF _____, YEAR _____

(Client)

(Parent, Guardian, or Authorized Representative)