Kristen Cheesman, MA, LMFT, CFI

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:________________________________

Date of Birth:_______________________________

I authorize the persons, agencies or institutions entered below to share and receive any and all information and records concerning my medical or psychological treatment with Kristen Cheesman, LMFT, CFI, and release the person agency or institution from any and all liability for providing such information.

LIMITS TO AUTHORIZATION

I wish to restrict my authorization entered above in the following specific ways:

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The above authorization shall continue in effect for a period of one year from the date entered below unless such authorization is rescinded in writing.

Signature of client or legal guardian:____________________________________

Date:_____________________

1369 Forest Park Circle, Suite 203, Lafayette, CO 80026 303-717-7630