Light Counseling, Inc.
2811 Linkhorne Drive, Suite B
Lynchburg, VA 24503

434.384.1594

# REQUEST FOR AUTHORIZATION TO RELEASE INFORMATION

I, _____ hereby authorize _____
Client's full name — Person's name, or put "No One"

Who is my _____, to do the following:
(Designate relationship: Spouse, friend, Mother, etc.)

_____ Confirm/Cancel Appointments _____ Leave Messages

_____ Participate in Counseling Sessions _____ Ask/Receive Billing Information

_____ Other: _____

I fully understand this request to release the above information and the implications of its release. My request is wholly voluntary on my part and I can revoke this consent any time. I hereby release the source of the information from any liability arising from their release. I authorize the above party to communicate with Light Counseling, Inc., by telephone about topics relevant to the above listed purposes for this release of information. I agree that a copy of this form is acceptable as the original.

_____ _____
Signature of Patient (if 18 or older) — Date

_____ _____
Signature of Parent/Guardian — Date

I witnessed that the person understood the nature of this release and freely gave his/her consent.

_____ _____
Signature of Witness — Date