

RELEASE OF INFORMATION

Client Name: _____ Phone: _____

Client Address: _____

City: _____ Zip: _____

I AUTHORIZE **SUNYOUNG LEE, LPCC**

TO OBTAIN INFORMATION FROM:

Attn: _____

Agency Name: _____

Address: _____

Phone: _____

OR GIVE INFORMATION TO:

Attn: _____

Agency Name: _____

Address: _____

Phone: _____

THE FOLLOWING INFORMATION CONTAINED IN MY RECORDS:

This authorization is valid for six months from the date below. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

Date: _____ Client or Parent/Guardian Signature: _____