**Lana Gollyhorn**

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**Authorization for Release/Exchange of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , authorize Lana Gollyhorn, M.A., Psychotherapist to release and/or exchange information about my case with the following parties (*please include full name, relation, address, phone number):*



Ms. Gollyhorn may share information obtained in sessions as well as her clinical impressions, both verbally and in writing. I understand that I may at any time revoke my consent. Without revoking my consent this is valid until my treatment with Lana Gollyhorn has been terminated. I release Lana Gollyhorn from responsibility or liability for the information provided according to the terms of this consent. I understand that the person with whom Lana Gollyhorn shares this information may re-disclose it and therefore my information is not further protected by HIPPA.

Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_