Paulo Lazaro, LCSW, CBT, EMDR

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Authorization to Release/Request Protected Information

Date: _____

I, _____ , authorize Paulo Lazaro, LCSW, CBT, EMDR to:

Release information to ( ) **OR** Request information from ( ):

Name: _____
Adress: _____
_____
Tel: _____
Email: _____
Fax: _____

The following information may be released: _____
_____
_____

For the purpose of: _____

Revocation: I understand that this authorization is subject to revocation by me at any time.

Expiration: This release/request will automatically expire 30 (thirty) days after termination of treatment or in ___/___/20___.

Client's Name: _____
DoB: _____
Client's Address: _____
_____ _____

Client’s Signature/Date: _____