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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, give full authorization to Impact Counseling and Consulting Services, LLC to furnish information regarding my mental health information to:

Name _____

Address _____

City, State, Zip _____

for the purpose of _____. This consent is subject to revocation by the undersigned, and remains in force for 365 days from the date of signature. By signing and dating this release of information, I allow the person listed below to share specific record information.

Name **Joseph Lee, LPC**

Impact Counseling and

Consulting, LLC

Client's Signature

Mental Health Representative

Date