

# Diana L. Saunders, MA, LPC

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## PERMISSION TO REQUEST RELEASE OF INFORMATION

DATE \_\_\_\_\_

I, \_\_\_\_\_, birth date, \_\_\_\_\_

authorize Diana L. Saunders, MA, LPC, to request release of information concerning me/or  
(fill in for minor, leave blank if above is filled in for self) \_\_\_\_\_

\_\_\_\_\_, birth date, \_\_\_\_\_

from/to: name \_\_\_\_\_ phone number  
\_\_\_\_\_ fax number \_\_\_\_\_.

Items and information to be released are: \_\_\_\_\_

\_\_\_\_\_.

I wish to exclude the release of the items and information pertaining to: \_\_\_\_\_

\_\_\_\_\_.

(none, if left blank).

The information will be used to promote counseling/psychotherapy.

I understand that I may revoke this authorization at any time by giving written notice to Diana L. Saunders, MA, LPC. Unless I revoke this authorization prior to such time, this authorization to request/release information shall expire when counseling is terminated.

\_\_\_\_\_

Signature of client or guardian

\_\_\_\_\_

Diana L. Saunders, MA, LPC

\_\_\_\_\_

Date

\_\_\_\_\_

Date