

RELEASE OF INFORMATION

I (client), _____, hereby give permission
to (therapist) _____ of Inner Light

Counseling and Holistic Center, 285 East Main St, Somerville, NJ, 08876 to release
information to and receive information from

Referring Doctor/Primary Care Doctor

Guidance Counselor/Other

Name _____

Name _____

Address _____

School _____

Address _____

Phone _____

Fax _____

Phone _____

Parent/Guardian

Name _____

Address _____

Phone _____

Signed _____

3rd Party Witness _____

Date _____