



AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Sign Post Relationship Solutions, Inc. to obtain/release information pertaining to my evaluation and/or treatment to/from:

for the purpose(s) of assisting in meeting the goals as set forth in therapy.

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date listed below.

I have been informed that I may revoke this authorization by written or oral communication to the Sign Post Relationship Solutions, Inc..

I certify that this form has been fully explained to me and that I understand its contents.

Signature of Client

Date of Authorization