MARTI WIBBELS, M.S., LMHC, LPC, PLLC

RELEASE FORM

I, _____, hereby authorize Marti Wibbels, M.S., LMHC, LPC, PLLC to release information pertaining to my evaluation and/or counseling sessions to:

Name: _____

Address: _____City: _____ State: ____ Zip Code _____

for the purpose of: _____

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for one year thereafter ending on: _____ (no ending date if not specified).

I have been informed that I may revoke this authorization by written or oral communication to Marti Wibbels, M.S., LMHC, LPC, PLLC. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____

Signature of Client Date of Authorization

_____ _____

Signature of Witness Date

marti@pbcounseling.com | 954.531.9154

This information is confidential.