Sallie Lowman, LMFT
Licensed Marriage and Family Therapist AL #321
205.613.3282 shlowman@bellsouth.net

CLIENT RELEASE OF INFORMATION

I, _____ hereby authorize Sallie Lowman, LMFT, to

obtain from/release to _____, information

regarding _____,
Client's name DOB

who resides at _____
Address City State Zip

The following information is requested:

____ Teacher's observations, progress notes, testing

____ Consultation

_____ Diagnosis

____ Treatment notes (specific dates)

_____ Psychiatric/Psychological evaluation

____ Other _____

The purpose of this disclosure is:

_____ to facilitate evaluation and treatment

This consent may be ended at any time by the client (parent or guardian if minor), but ending the consent will not cancel any action that has already been taken as allowed by this authorization. Unless the client wished to cancel this consent at an earlier time, it will automatically stop one year from the current date, and/or the event or condition indicated below:

a. Date_____ b. Event/Condition: _____

It is understood that the duration of this consent will not be longer than would be necessary and reasonable to carry out the purpose for which it was given.

_____ _____
Date Signature of Client or Person Authorized to Sign