

## RELEASE OF INFORMATION

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Client name: \_\_\_\_\_

I, \_\_\_\_\_ give permission to Kristina Schasker, MFT to release  
(Client or Parent/legal guardian)  
and/or exchange clinical information relevant to my or my child's diagnosis and treatment with  
\_\_\_\_\_.  
(Person/professional to be consulted)

This authorization will expire one year from the date of signature.

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Signature

Date

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