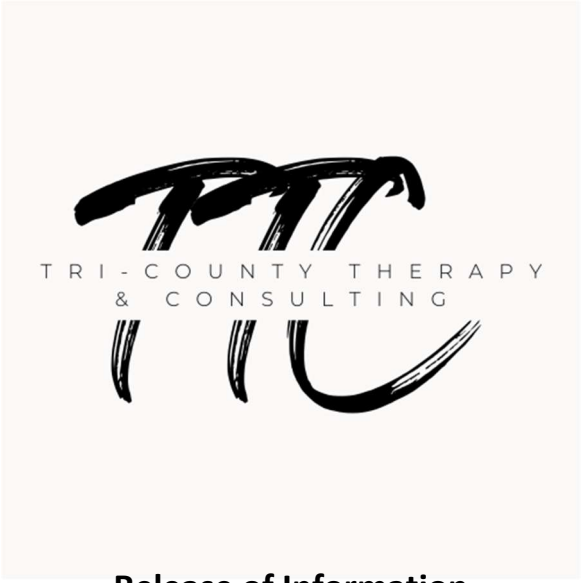

Release of Information

My signature below authorizes the release of any and all information unless otherwise noted regarding my treatment at Tri-County Therapy & Consulting to the following individual(s)/provider(s):

ADDRESS:_____

PHONE: _____

METHOD OF DISCLOSURE (I.E. PHONE, PARTICIPATION IN SESSION, ETC):

_____

PURPOSE OF RELEASE: _____

Dates covered: _____ to _____ (not to exceed 1 year)

Signature _____ Date _____