{Disclosure Limitation Addendum for Release of Information}

By signing below, I am authorizing _____ to have access to the following regarding my treatment:

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: _____