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## AUTHORIZATION FOR RELEASE OF INFORMATION FOR ALL BELOW LISTED:

Your attorney: Address: Phone: Fax: Email:

Opposing Attorney: Address: Phone: Fax: Email:

Attorney for child/GAL: Address: Phone: Fax: Email:

Your counselor: Address: Phone: Fax: Email:

Your child’s counselor: Address: Phone: Fax: Email:

“The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.”

I, , Date of Birth: , hereby authorize Michael L. Crane MA, LPC to request, receive or release information to or from **ALL OF THE ABOVE LISTED** for the purpose of evaluation and treatment. I affirm that everything in this form that was not clear to me has been explained to my satisfaction.

Signature Date

Parent or Guardian (if applicable) Witness