

**Craig A. Knippenberg, LCSW, M.Div., P.C.
Knippenberg, Patterson & Associates**

AUTHORIZATION TO RELEASE/RETRIEVE MENTAL HEALTH INFORMATION

I hereby consent to Craig A. Knippenberg, LCSW, M.Div., P.C. & Knippenberg, Patterson & Associates, including the therapist listed below, to Release information to the following parties. This includes written and verbal transfer of history, mental health, and treatment information, for the purposes of consultation and coordination with relevant professionals.

These Individuals Are As Follows:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby consent to Craig A. Knippenberg, LCSW, M.Div., P.C. & Knippenberg, Patterson & Associates, including the therapist listed below, to Retrieve information from the following parties. This includes written and verbal transfer of history, mental health, and treatment information, for the purposes of consultation and coordination with relevant professionals.

These Individuals Are As Follows:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION: I certify that this release has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

THIS authorization should be valid for:

- _____ 12 Months from the date of my signature;
- _____ Months from the date of my signature ; Or
- _____ Until thirty (30) days after the termination of treatment with Craig A. Knippenberg, LCSW, M.Div., P.C. (& Knippenberg, Patterson, & Associates), including the therapist listed below.

A facsimile or copy of this release shall be treated as an original.

Client's Name (please print)

Date

Client/Parent/Guardian Signature

Relationship to Client

Therapist's Signature & Credentials