1032 Turnpike Street
Suite 204
Canton, MA 02021

Renz Counseling

378 Page Street
Suite 6
Stoughton, MA 02072

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize
(print patient name)

_____ of Renz Counseling, LLC,
(print therapist name)

to contact: _____

_____

_____

_____

for the purpose of gathering pertinent information regarding my treatment plan.

This authorization shall be in effect until _____.
(.Date)

_____
Client name ***(please print)***

_____ _____
Client ***Signature*** Date

_____ _____
Clinician's signature Date