JENNIFER TARDELLI, MA, LPC, NCC
PSYCHOTHERAPY · WOMEN'S ISSUES

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RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Jennifer Tardelli, MA, LPC, NCC to exchange verbal and written information regarding my mental health treatment with :

_____

PRINT NAME & PHONE NUMBER

for the purpose of coordinating care. This authorization is effective for

90 days after this date:_____/_____/_____.

Printed Name:_____

Signature:_____

Date: ___/____/_____

If client is a minor, signature of parent/legal guardian:

Printed Name:_____

Signature:_____

Date: ___/____/_____