



## ***authorization to release information***

*Interventions is a division of Larry Fritzman Recovery Services Inc., a California Corporation.*

I hereby authorize Larry Fritzman Recovery Services to release and/or exchange information between:

(Treating professional) \_\_\_\_\_

Regarding the treatment of:

(Family member) \_\_\_\_\_

I understand the information is confidential and will be used for the benefit of treatment and consultation.

This authorization is for the period from \_\_\_\_\_ until one year after the termination of treatment. I agree that a fax or photographic copy of this authorization form will be as valid as the original.

Fax number: (415) 945-1888

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_