Center for Music Psychotherapy & Family Therapy
Kim McMillin RN, MA, MT-BC,LMFT, LPC
P.O. Box 6
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(303) 666-9091
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RELEASE OF INFORMATION FORM

Date________________

I, ____, Birthdate___________
Adult/Guardian/ Parent

Authorize Kim McMillin, RN, MA, MT-BC, LPC,LMFT to request or release information concerning me / my family
from/to____
Name of individual and/or organization

Items and information to be released are:

____

____

I wish to exclude the release of information pertaining to:
____
____
(none if left blank)

This information will be used to promote the counseling process.

I understand that I may revoke this authorization at any time by giving written notice to the Center for Music Psychotherapy and Family Therapy. Unless I revoke this authorization prior to such time, this authorization to release information shall expire 2 years from the date of my signature.

_____________________________________ _________________________
Signature of Client Date

_____________________________________ _________________________
Witnessed by Witness' relationship to Client