



# AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

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

Name of Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby provide authorization for the mutual exchange of information concerning the above named adult or child between the staff of Shrink Rap, Inc. and/or their designee and the following parties:

**NAME PHONE ADDRESS of Persons/Organizations Shrink Rap may contact**

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The purpose(s) for releasing these records will be:  
assessment, planning, and \_\_\_\_\_

I hereby release **Dr. Gurri and Shrink Rap** and/or his/her designee from any liability, which may arise as a result of the use of the information contained in the records released. Written consent must be obtained to disclose the released information to any other party. I certify that I am the client or patient, or the parent or legal guardian of the above-mentioned child or adult with a guardian or that I am of legal age and have the authorization to sign this release.

\_\_\_\_\_  
1. *Printed Name of Authorized Signature*

\_\_\_\_\_  
1. **Authorized Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
2. *Printed Name of Authorized Signature*

\_\_\_\_\_  
2. **Authorized Signature**

\_\_\_\_\_  
**Date**