

AUTHORIZATION FOR RELEASE OF INFORMATION

J. Morgan Grey, LPC, REAT
The Power Company
4625 S. Wendler Drive, Ste 111, Tempe, AZ 85282

I, _____ hereby authorize
Print or type Client name

Provider Name: _____

Address: _____

Telephone: _____

To disclose records and information obtained in the course of my diagnosis and treatment to
J. Morgan Grey, LPC, REAT of The Power Company.

I, _____ hereby authorize
Print or type Client name

J. Morgan Grey, LPC, REAT of The Power Company to provide the above named provider with
information regarding my insurance benefits and to disclose and discuss all information needed for the
medical necessity and appropriateness of my care.

I understand that I can limit my disclosure to specific types of information and have noted disclosure
limitations as follows. (check and initial #1 or #2):

- | | |
|---|-------------------------------|
| 1. _____ No disclosure limitations | (Client initials)
1. _____ |
| 2. _____ Disclosure limited to the following types of information | 2. _____ |

I understand that I can revoke this consent at any time, except to the extent that action has been taken in
reliance of this consent prior to my revocation. I understand that this authorization will expire two
years after the date of my signature, or, if not earlier revoked, it shall terminate on:

Description of Event, Date or Condition:

I also understand that I have a right to a copy of this authorization.

Printed Client Name _____

Signature of Client, Guardian or Authorized Representative of Patient

Date