Protected Health Information Release Waiver

Name of client_____

Address_____

City, State, Zip _____

I authorize the following individuals:

Name	Address	Telephone

To share information and discuss aspects of their treatment with Positive Solutions Therapy/Celia Marchese, LMHC, LMFT.

_____ _____

Client/Legal Guardian Date

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celia@positivesolutionstherapy.com