

Release of Information

Sharon Thompson Wilson
LMFT #19815

509 4th Street Suite A
Davis California 95616
530-304-3004

I (we) authorize the release of information to be exchanged and disclosed between Sharon Thompson Wilson and the following person(s) as it effects my (our) treatment.

I (we) agree to this release of information for 180 days, or until written change is received by Sharon Thompson Wilson.

_____ Client Name (print)	_____ Client Signature	_____ Date
_____ Client Name (print)	_____ Client Signature	_____ Date

Signature and date of Sharon Thompson Wilson, LMFT