

**Pamela Chambers**  
**11111 N. Scottsdale Ste. 205**  
**Scottsdale, AZ 85254**  
**Voice: 480-703-0606 or 480-619-4349**  
**Fax: 480-203-2784**

**Release of Confidential Information**

I \_\_\_\_\_ hereby authorize and direct  
(Client's Name) (Date of Birth)

Pamela Chambers and: \_\_\_\_\_  
(Print name, address and telephone number):

\_\_\_\_\_ to release and exchange information related to my physical, psychological, and emotional health.

In authorizing the release of this confidential information, I do hereby release Pamela Chambers from **any and all** liability resulting from **any and all** use of this information.

This authorization is valid until \_\_\_\_\_  
(Date not to exceed one year)

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Client Signature of  
Parent, if client is a minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature Date

**A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE  
CONSIDERED VALID.**