

# AUTHORIZATION FOR RELEASE OF INFORMATION

## *Compass Counseling Center*

2685 South Rainbow Blvd  
Suite 209  
Las Vegas, NV 89146  
Phone: (702) 368-4585  
Fax (702) 368-2177

I hereby authorize the exchange of information regarding

\_\_\_\_\_  
(patient name)

Between Compass Counseling and

\_\_\_\_\_  
(person or agency)

This authorization for release is subject to revocation at any time  
except to the extent action has been taken in reliance thereon.

This authorization will expire on or upon

\_\_\_\_\_  
(date, event or condition)

\_\_\_\_\_  
Date

\_\_\_\_\_  
signature

\_\_\_\_\_  
witness