**Ashton Martini, M.S.**
Licensed Marriage & Family Therapist and
Licensed Alcohol & Drug Counselor
7331 West Charleston Blvd., Suite 140
Las Vegas, NV 89117
Phone (702) 217-6604
ashton@lasvegasnvtherapist.com

# AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________________________________, authorize the following

(Full Name)

agencies or persons:

| AGENCY / PERSONS A | AGENCY / PERSONS B |
|---|---|
| Ashton Martini MS, LMFT & LADC<br>7331 West Charleston Blvd., Ste 140<br>Las Vegas, NV 89117<br>(702) 217-6604 | ___________________________________<br>(Name, Title, Organization)<br>___________________________________<br>(Address)<br>___________________________________<br>(City, State, Zip)<br>___________________________________<br>(Phone Number)<br>___________________________________<br>(Fax) |

To make the following transaction:

____ Ashton Martini MS, LMFT & LADC (Agency/Person A) to disclose information specified below to Agency/Person B

_____Agency/Person B to disclose information specified below to Ashton Martini MS, LMFT & LADC (Agency/Person A)

____ Agency/Person A and B to disclose information specified below to each other.

Regarding (client's name):______________________________________.

I authorize the release of the following information: ____________________________________

For the purpose of: ______________________________________________________________

This release is effective from ____________ to ____________

I understand that I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

Client Signature ________________________ Parent/Guardian Signature____________________

Witness Signature__________________________ Date ________________