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AUTHORIZATION FOR RELEASE OF INFORMATION

Release of information regarding: _____

I, _____, hereby authorize
Tara Schroeter, M.A., LMFT to disclose, obtain or exchange confidential information
regarding the above named person with the party named below:

Name: _____

Organization _____

Address _____

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Fax Number _____

Type of release: Mutual exchange of information _____

Other (explain) _____

Purpose of disclosure: Assessment, diagnosis and/or treatment _____

Other (explain) _____

Release or transfer of this information to any other person or organization not specified in
this document is prohibited by law and requires additional releases. I have a right to
request a copy of this authorization.

Signature of person empowered to authorize release: _____

Today's date: _____

This release expires one year from date signed unless revoked earlier.