OC COASTAL COUNSELING
DONNA M. CAROLLO, M.A., LMFT
Couple, Family & Individual Therapy

Authorization for Release of Information

I, _____, with my signature below, give authorization for Donna M. Carollo, M.A., Licensed Marriage and Family Therapist, Licesne #MFC80214, to discuss information relevant to my case with the below-named person:

Name: _____
Address: _____
_____
Phone: _____
Relationship: _____

Information discussed is to be limited to:
_____
_____
_____

This authorization is valid from the date of authorization until termination of treatment with Donna M. Carollo, MA, LMFT, unless otherwise indicated.

Dated: _____
Client Signature:_____

657 CAMINO DE LOS MARES, SUITE 241,
SAN CLEMENTE, CA 92673
(949)547-2957 PH • (949)498-8824 FAX
WWW.OCCOASTALCOUNSELING.COM
DONNAMCAROLLO@GMAIL.COM