

**New Reflections Clinical Services**

29W335 Renouf Drive, Warrenville, Il. 60555  
630-346-9266

**RELEASE OF INFORMATION**

I----- hereby authorize New Reflections Clinical Services to  
release information pertaining to my treatment plan and/or counseling sessions to:

\_\_\_\_\_  
\_\_\_\_\_

for the purpose of: \_\_\_\_\_

(indicate the specific reason)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that authorization shall remain valid from the date of my signature below and for 12 months thereafter ending on:

\_\_\_\_\_

I have been informed that I may revoke this authorization by written or oral communication to New Reflections Clinical Services. I certify that this form has been fully explained to me and that I understand its contents.

Signature of Client

Date of Authorization

x \_\_\_\_\_

Signature of Witness

Date of Authorization

francoise mastroianni, lcpc,cadc,ceda,ccsat.

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