ELISABETH A. EDWARDS, MA, LMHC, LMFT

I, _____, hereby authorize

ELISABETH A. EDWARDS, MA, LMHC, LMFT AND ASSOCIATES

at

500 E University Ave, Ste C
Gainesville, FL 32601

to release information for _____ THERAPEUTIC _____ BILLING purposes only to:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

ADDRESS: _____

_____

CLIENT NAME: _____

CLIENT SIGNATURE: _____

DATE: _____

THERAPIST NAME: _____

THERAPIST SIGNATURE: _____

DATE: _____