

**Aden Burka Wright, LCSW**  
**7821 Maple St. New Orleans, LA 70118**  
**(504) 303-4034 • aden@adenburkawright.com**  
**www.adenburkawright.com**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, with my signature below, give authorization for Aden Burka Wright, LCSW to discuss information relevant to my case with the below-named person:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Information discussed is to be limited to:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization is valid from the date of authorization until termination of treatment with Aden Burka Wright, LCSW, unless otherwise indicated.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_