Alyson Landeros, LMHC, MCAP, CCTP
Licensed Mental Health Counselor
License # 13870

Consents to Release Information

I hereby consent for *Alyson Landeros, LMHC, MCAP, CCTP* to contact the following parties as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at *Alyson Landeros, LMHC, MCAP, CCTP* and for 90 days following my last visit unless expressly revoked by me in writing.

Name: _____ Phone #: _____

Address: _____
(Street/PO Box/Apt. Unit #) (City) (State) (Zip)

Name: _____ Phone #: _____

Address: _____
(Street/PO Box/Apt. Unit #) (City) (State) (Zip)

Name: _____ Phone #: _____

Address: _____
(Street/PO Box/Apt. Unit #) (City) (State) (Zip)

_____ _____
Client Signature **Date**