Alicia D. Hart, MMFT, MDiv. Ed.S., LMFT

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

I,_____, SSN:_____DOB:_____

(Name of Client)

by completing and signing this form, understand that at times an important aspect of counseling/therapy is coordination/consultation with other individuals, health care providers or community agencies which may be of assistance to me or my family. I also understand that at times it is necessary to communicate with insurance companies to facilitate reimbursement. Therefore, I hereby authorize and request for my therapist to communicate with the individual(s) or agency listed below:

_____

(Individual(s)/Agency Name)

_____

(Address and Phone/Fax Number)

may release/receive all confidential medical, psychological, psychiatric, alcohol and drug treatment, education, legal and/or other appropriate information required in the course of my evaluation and treatment (or those of my minor children) to/from:

_____Alicia D. Hart, Therapist

Exceptions:

- ❑ I specifically request that the therapist only **Release To** the listed agency/individual(s).
- ❑ I specifically request that the therapist only **Receive From** the listed agency/individual(s).
- ❑ I specifically request that only verbal communication of information be exchanged between the therapist and the listed agency/individual.
- ❑ Other: _____

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of information.

This consent will expire one year from date this release is signed,
unless other wise noted by the following date_____/_____/_____

Client, Parent, Guardian _____ Date _____