ART OF THE HEART
COUNSELING SERVICES LLC

CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Client's Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

FOR MINORS: Parent/Caregiver/Legal Guardian's Name: _____

I hereby authorize and direct:

Therapist Name: _____ at Art of the Heart Counseling Services LLC

to release to and/or exchange information with (who you want to release the information to):

Name: _____

Address: _____

Phone/Fax/Email: _____

The purpose of this release is for:

_____ Treatment/Coordination of care with another provider
_____ Education/Coordination of care to meet the client's educational needs
_____ Court/Legal
_____ Insurance plan or third-party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize more sessions or to process claims, or to fulfill administrative review by plan
_____ Other: _____

The information released will be limited to:

_____ Diagnosis only
_____ Treatment Summary (pertinent psychiatric and psychosocial history, treatment plans and progress)
_____ Any information (educational, medical, court-related, etc.) deemed necessary to coordinate care
_____ Gather information only from the collateral/person(s) identified on this form.

By signing this authorization form:
I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

The requesting party certifies that information will not be used for any other purpose than its intended use and will not be re-released to another party. The client understands that s/he has the right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon.

SIGNATURE: _____ PRINTED NAME: _____ DATE: _____

RELATIONSHIP TO CLIENT: _____