sacred art
COUNSELING & WELLNESS

Consent for Release of Information

Client Name: _____Date of Birth: _____/_____/_____

I, _____ hereby authorize Sacred Art Counseling and Wellness, LLC to:

RELEASE TO: RECEIVE FROM:

Name: _____

Address: _____ Phone: _____

THE FOLLOWING INFORMATION:

Case Progress

Progress Notes

Treatment Recommendations

Attendance

Psychological Reports

Diagnosis and Diagnostic Impressions

AND/OR _____

FOR THE PURPOSE OF: Coordination of Services Treatment Recommendations Attendance Compliance AND/OR_____

I understand that my authorization will remain effective from the date of my signature until _____, and the information will be handled in compliance with all confidentiality laws, and that I may revoke the authorization at any time by written, dated communication.

Client's Signature_____ Date_____

Guardian's Signature_____Date_____

(If client is under 18 years old)

Witness _____ Date_____