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|  | The Healing Place**Release of Information Consent Form** |

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| **Client’s Name:** |  | **Client’s Date of Birth:** |  |
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| **Parent/Guardian Name:** |  |
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| Please specify which types of information you consent for The Healing Place to release, receive, and exchange by checking the box on the left: |
|[ ]  Information about scheduling appointments and treatment attendance  |
|[ ]  General verbal summary of assessment, diagnosis, treatment goals and progress |
|[ ]  General written summary of assessment, diagnosis, treatment goals and progress |
|[ ]  Full copy of the written treatment record |
|  |  |
| *Please identify with whom The Healing Place may communicate about the client’s protected health information to by filling in the following:* |
| *Name:* |  | *Organization:* |  |
| *Phone Number:* |  | *Address:* |  |
| *Relation to Client:* |  | *Email:* |  |

[ ]  *I hereby give my permission for The Healing Place Therapy Practice to release, receive, and exchange protected health information with the person(s) and/or institutions named above:*

[ ]  *I understand that the release and exchange of information authorized here will be limited to what is prudently necessary for the delivery of expedient and successful psychotherapeutic treatment.*

[ ]  *I understand that I may rescind this permission at any time and for any reason by giving a written notice to my therapist.*

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| *Client’s Signature* | *Date* |
|  |  |
| *Parent’s/Guardian’s Signature*  | *Date* |