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

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| **Client’s Name:** | | |  | | **Client’s Date of Birth:** | |  | |
|  | | |  | |  | |  | |
| **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* |