GRATEFUL HEART
HOLISTIC THERAPY CENTER

Authorization Consenting To Release Of Information

I authorize_____ (THERAPIST) to discuss and/or exchange clinical information (verbally and/or in writing) pertaining to me and my treatment in psychotherapy or evaluation with any person/s or staff of clinic, office, agency, or institution/s named below:

1. _____

2. _____

3. _____

4. _____

For the following reason(s):

- ☐ Consultation
- ☐ Treatment Coordination
- ☐ Evaluation
- ☐ Other_____

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed.

_____ Date_____

Name (Print)

_____

Name (Signature)

_____ Date_____

Name (Print)

_____

Name (Signature)