HEALING WITH GRACE COUNSELING CENTER

Release of Information

I, _____, authorize my therapist/practitioner _____

_____ to disclose the information initialed below TO and/or FROM

_____.
(Person or agency to which disclosure is to be made)

Purpose of disclosure:

_____ Diagnosis

_____ Treatment Plan

_____ Assessment

_____ Progress Notes/Intervention

_____ Discharge Summary/Status

_____ Case Management

_____ Payment

_____ Other, please specify: _____

I understand that my records are protected under federal regulations and Nevada statutes and administrative regulations and any further discloser is prohibited without the consent of the undersigned. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance to it. I understand that this authorization will automatically expire twelve (12) months after date signed.

I further release my therapist/practitioner from any liability arising from the release of information to the person/agency designated above. I acknowledge that the information to be released was fully explained to me and this consent is given of my free will.

_____

Client Written Full Name Date

_____

Client Signature Date

_____

Therapist/Practitioner Date