Heartwood Counseling
Peggy C Mahan, MA, LPC, Play Therapist

heartwoodcounseling.com

Authorization to Release Confidential Information

Client Name: DOB:

I, _____ authorize Heartwood Counseling, Peggy C. Mahan,

_____ to disclose to: to receive from:_____

_____
Name

_____
Phone Number

The following information:

Progress Notes _____ Consultation _____ Test Results/ Reports _____ Diagnoses _____

Treatment Goals/ Plans_____ Acknowledge Treatment _____ Other _____

For the purpose of: _____

I, the undersigned, understand that I may revoke this consent at any time through written form except to the extent that action has already been taken in reliance on it and that in any event this consent shall expire sixty (120) days after the date of client discharge unless another date is specified.

Date, event, or condition upon which this consent expires: _____

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 OFR, Part2) prohibits you from making further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Date Signature of Client/ Parent/ Legal Guardian

Signature / Date _____

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