**Amanda Conner Counseling, LLC**

***AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client Name)

by completing and signing this form, understand that at times an important aspect of counseling/therapy is coordination/consultation with other individuals, health care providers or community agencies which may be of assistance to me or my family. I also understand that at times it is necessary to communicate with insurance companies to facilitate reimbursement. Therefore, I hereby authorize and request for my therapist to communicate with the individual(s) or agency listed below:

(Individual(s)/Agency Name)

(Address and Phone/Fax Number)

may release/receive all confidential medical, psychological, psychiatric, alcohol and drug treatment, education, legal and/or other appropriate information required in the course of my evaluation and treatment (or those of my minor children) to/from: *Amanda M. Conner, MMFT, LMFT / Amanda Conner Counseling, LLC*.

Exceptions: 🞎 I specifically request that the therapist only **Release To** the listed agency/individual(s).

🞎 I specifically request that the therapist only **Receive From** the listed agency/individual(s).

🞎 I specifically request that only verbal communication of information be exchanged between the

therapist and the listed agency/individual.

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this consent at any time by informing Amanda Conner Counseling, LLC in writing, but the revocation has no effect on action previously taken. Otherwise, this release is effective for one year past the date of signature.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of information.

Client, Parent, Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_