Client Information

Full name_____ Today's Date_____

Date of Birth_____

Release Information

I, _____ am authorizing Healing Hope Counseling to ☐release and/or ☐ obtain information from the mental health records of the client indicated above to/from:

Name of person/facility_____

Address_____

Phone Number_____

Email _____

I authorize information to be shared by ☐ mail ☐ phone ☐ email.

The following information may be released or obtained:

☐ Entire Record ☐Medical/Medication Information ☐Treatment Plans

☐ Mental Health Assessment ☐School Information ☐Progress Updates

☐Other_____

Patient Signature_____ Date_____

Counselor Signature_____ Date_____