HOPE RISING COUNSELING, LLC

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CONSENT AND AUTHORIZATION TO EXCHANGE INFORMATION

Name: ____   Date of Birth: ________________

I request and authorize the exchange of information concerning diagnosis, treatment, intervention, assessment, academic planning, and medical/medication issues for the above named individual ***to and from*** *the individuals listed below, as part of treatment at Hope Rising Counseling, LLC. Information may be exchanged via written, verbal, or electronic communication. This authorization is signed with the understanding that information shall not be used for any purpose other than specified, shall be maintained in a confidential manner, and shall not be disclosed by the recipient of this information to any other persons, groups, or organizations without specific written permission.*

Name	
Facility	
Address	
Phone	
Email	

Client Signature: _______________________________   Date: ____________________
(if 18 years of age or older)

Parent Signature: _______________________________   Date: ____________________

Therapist: ______________________________________   Date: ____________________

This release is valid for the duration of treatment or until rescinded by client/guardian