Healing heARTS Counseling, LLC
354 NE Greenwood Ave Suite 215
Bend, Oregon 97701
(541) 668-7613

CONSENT FOR DISCLOSURE OF INFORMATION

Client Name: _____ Parent/Legal Guardian (if applicable): _____

I, _____, hereby provide authorization for Healing heARTS Counseling LLC to provide the following information:

_____ Dates of Service _____ Number of Sessions _____ Multiaxial Diagnosis

_____ Progress Summary _____ Other, specify_____

To the following recipient:

Name: _____

Address: _____

Phone Number: _____

*Please note: If you are using insurance as your payment method, I will need your consent to release your mental health records and information to your insurance company so they can process your claim. If you currently have a CPS case open and would like me to work with your case manager, I will need your consent to release your mental health records and information. If you have more than one entity you would like consent to release information for, please fill out a form for each entity.

**Information released is strictly confidential and is accepted for use solely by and for the parties, as stipulated above for the purpose of providing mental health services.

"I now authorize this release and stipulate this authorization expires, unless otherwise noted, upon termination of treatment."

_____
Client Name (Print)

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Counselor Signature Date