**Paige O'Shea, LMFT**
**A Mind Body and Soul Healing**
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## CONSENT TO RELEASE INFORMATION

**I,_____, hereby give consent for the following agencies or persons to release information to each other:**

**Paige O'Shea, LMFT and :**

_____

_____

_____

**To assist in my counseling process, the following information may be released:**

_____

**for the purpose(s) of collaboration.**

**I understand that this consent is to begin on the date that this agreement is signed and is to be revoked at the end of one year from the date signed unless otherwise specified. This consent does not allow disclosure to any other person or agency other than those named on this document.**

**I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as AIDS. I further understand that my medication information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.**

_____
**Client**

_____
**Parent/guardian**

_____
**Date signed**

_____
**Date revoked**

_____
**Witness**

***This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains.***