AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, ____, __________DOB, authorize **Pathways to the Heart…,LLC** to **discuss** (verbally or in writing) anything that has been brought up during our therapy for the purpose of collaboration of your treatment, **with** any person/s or staff of clinic, office, agency, or institution/s named below (with the phone number to contact them) <u>and</u> **receive** any relevant information **from** them. Without a release of information no information can be shared or received, unless circumstances of mandated reported occur (stated in the Service Agreement).

1. ____

2. ____

3. ____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time, otherwise it will expire 90 days after termination of treatment.

This disclosure of information and records authorized by Client is required for the following purpose:
For the following reason(s):

____ Consultation,
____ Evaluation,`
____ Other: ____

Client Name (printed): ____
Client Signature: ______________________________ **Date:**______________

Second Client's Name (print) – as needed______________________________
Signature ______________________________ **Date** ______________

Signature of Parent/Guardian:______________________ **Date:**______________
(If client is under 18)

Therapist/Witness Name: *Ashlie Befus, LMFT, M.Ed, CST*
Therapist/Witness Signature: ______________________ **Date:**______________