AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, authorize the following agencies or persons:

(client's full legal name)

AGENCY/PERSON(S) A:

Inspired Art Therapy, INC.
Zandi Schlegel, ATR-BC, LCPC, LMHC
3695 Kings Row #6
Reno, NV 89503
775.298.5392
hello@inspiredarttherapy.org

AGENCY/PERSON(S) B:

_____
(organization, name, title)

_____
(address, city, state, zip code)

_____
(phone)

_____
(email)

To make the following transaction(s):

____ Inspired Art Therapy, INC. (Agency/Person A) to disclose information specified below to Agency/Person B

____ Agency/Person B to disclose information specified below to Inspired Art Therapy, INC. (Agency/Person A)

____ Agency/Person A and B to disclose information specified below to each other

Regarding (client's full legal name): _____ Client DOB: _____

I authorize the release of the following information: _____

For the purpose of: _____

This release is effective from: _____ to_____ , or expires one year from today's date.

AUTHORIZATION AND SIGNATURE

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

I authorize this release of information, and understand that I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

Client/Guardian Signature_____

Date_____