Melanie Arons Counseling & Consulting, LLC
Melanie Arons, MA, LCPC
899 N. Skokie Blvd. suite 430
Northbrook, IL 60025
312-316-6362

Consent to Release/Request Client Records/Information

To: _____
_____

Phone: _____
_____

Client: _____
_____

DOB: _____

_____Educational Records
_____Health/Medical Records
_____Psychiatric Evaluations
_____Psychological/Neurological Assessments & Diagnosis
_____Therapy Notes
_____Treatment Evaluation
_____Other:
_____Any and all records/information

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Melanie Arons and Melanie Arons Counseling & Consulting, LLC (treating therapist) from any and all liability arising from release and disclosure of the information and records. I/We understand that I/We have the right to inspect and copy the information to be disclosed. I/We understand the I/We may refuse to consent to disclosure prior to the information being sent.

I/We have read the above and had the opportunity to ask questions concerning this consent., including the consequences , if any, of refusal to consent. This consent is valid for one year from the date it is signed. This release expires on _____/_____/____.

_____ _____
Client Signature Date

Witnessed by: _____
Therapist Signature