## Heal Together Counseling: Release of Information

By signing this form, I authorize the release of my confidential health information to the identified party listed below.

Patient Name: _____

Date of Birth: _____

**I consent to releasing the following information:**

| | | |
|---|---|---|
| ☐ Complete Record | ☐ Progress Updates | ☐ Medications |
| ☐ Treatment Plan | ☐ Safety Plans | ☐ School Records |
| ☐ Progress Notes | ☐ Court Orders | ☐ Discharge Summary |
| ☐ Physical/Immunizations | ☐ Hospital Records | ☐ Other: |
| ☐ Evaluations | ☐ Medical Records | |

| **Agency** | **Release To:** | **Receive From:** |
|---|---|---|
| Agency: Heal Together Counseling. LLC<br>Contact: Rebecca Searles, MSW, LICSW<br>Address: 194A Pleasant St, Suite 206, Concord, NH<br>Phone: 401-584-4325<br>Fax: 978-616-7325 | ☐<br>Initial | ☐<br>Initial |
| Agency:<br>Contact:<br>Address:<br>Phone: | ☐<br>Initial | ☐<br>Initial |

**The purpose/reason for this release of information is as follows:**

_____

**Signature:**

_____ _____

Client Name Parent/Guardian Signature

_____ _____

Client Date of Birth Parent/Guardian Name

_____ _____

Date Relationship to Client