HeART Revolution Therapy and Counseling, LLC
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Authorization for Release of Information

I, _____(full name, self or guardian), _____(DOB)
authorize HeART Revolution Therapy and Counseling, LLC to release/obtain information to/from the following individual(s) or organization(s) regarding (specific type of information to be released, treatment plan, diagnosis, behavioral health plan, biopsychosocial info, physical health related information that could be helpful in coordinating mental health services:

Other:

1. Primary Care Provider (doctor or pediatrician required if utilizing Medicaid) :

2. Dentist (required if utilizing Medicaid):

3. School (if applicable)

4. Other/Name/Affiliation:

Purpose for release/receipt of information: Coordination of mental health services. Conditions of revocation of release: Written revocation by the client.

This consent expires on whichever of the following occurs first (circle one)
One month after the end of treatment OR Date:

I further agree to hold HeART Revolution Therapy and Counseling, LLC harmless for any use of this information made by a recipient authorized under this release, recognizing that HeART Revolution Therapy and Counseling, LLC will have no control over such use once the information is released.

My signature authorizes HeART Revolution, LLC to release and obtain information with the above agencies.

Client's First Name Last Name

Client's Signature:

Date

Parent/Guardian Signature (if client is under age 18)

Date

Patient/Guardian declines to release any information(sign here)_____