H. Mari Grande

Art and Trauma Therapist

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Request/Authorization to Release Confidential Records and Information

I hereby authorize the following to release information about _____.

Person or facility to release information:

_____

Address: _____

Email: _____

Phone number: _____

- ❑ They may exchange information in written and/or verbal form with Ms. Grande & Ms Grande may exchange information with them.
- ❑ Information will be release for purpose of evaluation, treatment, or care.

The information to be disclosed can include but is not limited to: Intake and discharge summary. Medical history and evaluation(s), Mental health evaluations, Developmental and/or social history, Educational records, Laboratory &/or test reports, Progress notes, and treatment or closing summary.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, upon termination of my work with Ms. Grande, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of client	Printed name	Date