Center for Therapy & Mediation

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CONSENT FOR RELEASE OF INFORMATION

I authorize release of the medical and/or mental health records to and from the person, or facility, or his/her designate and their support and administrative staff listed below.

Please include name, complete mailing address, telephone number, and fax number.

Name: _____

Mailing Address: _____

Telephone #: _____ Fax # (If known): _____

I understand that the release of this information is to permit my treating therapist, other healthcare practitioners, and/or members of my treatment team to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken already. I further understand that I have a right to receive a copy of this authorization upon my request. By signing this document, I attest that I am providing consent for myself or am legally able to do so on behalf of the client.

Client Name (Print): _____

Client (Signature): _____ Date: _____

IF THE CLIENT IS UNDER 18, a parent or legal guardian must sign this document. Please print your first and last name, check your relationship to the client, and sign your complete name (with date) on the lines below. Thank you.

Guardian Name (Print): _____

Guardian Signature: _____ Date: _____

Clinician: Joy Quanrud Grimsley, MFT, LCADC-I, EMDR

(Signature) _____ Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.