THE HOUSE OF HOPE

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Afton Location:
3411 St. Croix Trail South
Afton, MN 55001

St. Croix Falls Location:
2070 Hwy. 8
St. Croix Falls, WI 54024

AUTHORIZATION TO RELEASE/DISCLOSE CONFIDENTIAL INFORMATION

This form is to be completed and signed by client or parent/guardian (if client is a minor). A signed form authorizes the release of requested information from your clinical record to an individual or facility.

Client Name: _____ DOB: _____

Parent/Guardian Name (if client is a minor):_____

Hereby authorize ____Release to ____Obtain from ____Exchange with

Name of Individual/Provider: _____

Name of Agency: _____

Address of Agency: _____

City: _____ State: _____ Zip: _____

Phone #:_____ Fax #:_____

Information to be shared:

____Diagnostic Impressions ____Case Notes ____Case Summary
____Psychological Testing ____Psychological Reports Other: _____

Please forward information to:

____Karen Heyer, LMFT ____Lora Jaecks, MFT ____Shana Link, PC

I understand that this material is confidential and will become part of my records with the authorized person or agency indicated and that it will not be shared with other agencies without written permission. However, I also understand that records are subject to review by person's or agency's supervisor. Inquiring about supervision is recommended.

I may revoke this consent at any time and that upon completion of the continuation of therapy, or after twelve months, this consent will automatically expire.

_____ _____

Client/Parent/Guardian Signature Date