HEALING WITH GRACE

Release Of Information

I, _____, authorize _____ (Therapist)

and Healing with Grace Counseling Center to disclose the information initialed below TO and/or FROM

_____. (Person or agency to which disclosure to be made)

Purpose of disclosure:

_____Diagnosis

_____Treatment Plan

_____Assessment

_____Progress Notes/Interventions

_____Discharge Summary/Status

_____Payment

_____Other (specify):_____

I understand that my records are protected under federal regulations and Nevada statutes and administrative regulations and any further discloser is prohibited without the consent of the undersigned. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance to it. I understand that this authorization will automatically expire twelve (12) months after date signed.

I further release _____ (therapist) and Healing with Grace Counseling Center from any liability arising from the release of information to the person/agency designated above. I acknowledge that the information to be released was fully explained to me and this consent is given of my free will.

Client Signature _____ Date _____

Therapist Signature _____ Date _____