



Release of Information Consent

I hereby authorize: _____

To share with and/or forward/receive information to:

_____ (therapist) at Healing Hearts Therapy. It is understood that this consent to release/receive information will expire upon written notice.

Date of Treatment: _____

Specific information requested includes:

Purpose for this disclosure:

_____ Pa

Client name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Parent/guardian signature if minor client: _____