

# ***Gift of Psychotherapy***

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## **Consent for the Release of Confidential Information**

I, \_\_\_\_\_, hereby authorize release of patient/client records and any other details of my care between:

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**AND**

For the purpose of assisting in the evaluation of my treatment and/or development of my treatment plan.

The consent expires upon the termination of my treatment or on the date specified: \_\_\_\_\_

I have had this explained to me and fully understand this request/authorization to release records and information; including the nature of my 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, except to the extent that action based on this consent has already transpired.

Signature of Client: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Therapist: \_\_\_\_\_ Date \_\_\_\_\_