stone cottage counseling
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404.490.1865 | dana@stonecottagecounseling.com

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to communicate with them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating care for you.

I, _____ (client), hereby authorize Dana Goldman and the following party or parties to discuss my mental health treatment information and records.

(1) _____

(2) _____

(3) _____

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

_____

_____

Client's Signature:_____ Date: _____

Parent's/Legal Guardian's Signature:_____ Date: _____

Therapist's Signature:_____ Date: _____