Consent to Release Information

Client Name

First Name Last Name

Client Date of Birth

Month Day Year

I Authorize:

Salathiel Reagan, LMHC

4630 W Jefferson Blvd, Suite 3, Fort Wayne, IN 46804

To disclose and/or obtain treatment information from the following:

Name

First Name Last Name

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number

Area Code | Phone Number

Email

example@example.com

Please sign below if you agree to release ***all*** of your Protected Health Informaiton (PHI).

If you are limiting the information that is released, please list only the information you agree to be released in the field below.

List limited PHI to be released

By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present written revocation to my therapist. I understand that once information is disclosed as per my authorization, receipt, in accordance with the applicable laws and regulations, my re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of Client or Legal Guardian

Date Signed

Month | Day | Year