HAVEN

COUNSELING & COLLECTIVE

Authorization to Obtain or Release Confidential Information

I, _____ , authorize Haven Counseling Collective, to release / obtain information that is pertinent to my therapy or evaluation with any other person(s) or staff of clinic, office, agency or institutions(s) named below.

_____

(Contact Information)

_____

(Contact Information)

_____

(Contact Information)

Reason(s) for the release of information:

☐ Consultation

☐ Course of Psychotherapy/Diagnosis

☐ Evaluation

☐ Other _____

_____ _____

Signature Date

This consent is in effect for one year from the date of signing, unless revoked in writing or until the termination of therapy. I understand that I may revoke this consent at any time. I understand that any cancellation or modification of this authorization must be in writing.