Authorization for Release of Information/Consent of Treatment

MORNING LIGHT
COUNSELING

Client Name/s:

I authorize that Morning Light Counseling and the individuals and entities listed below may mutually disclose and release my personal health information. In initialing and signing this authorization, I am giving Morning Light Counseling permission to disclose my health information to those individuals and entities listed below. I am also agreeing to the disclosure of information to Morning Light Counseling from the individuals and entities listed below. This may involve any records including assessments, reports, clinical test results, professional opinions and all information relating to psychological, medical, educational and any other pertinent information.

Upon request, I may revoke this authorization at any time by sending a written notice to Carrie Wrigley, LCSW, at Morning Light Counseling. Any disclosures that have been made to the individuals or entities listed below prior to this written notice will not be affected by the revocation.

I understand that the information used in this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the confidentiality regulations of Morning Light Counseling.

In listing individuals and entities below, I waive my right of privacy of information disclosed that is hereby authorized.

This authorization is only valid during treatment at Morning Light Counseling, or three months after a termination of treatment has been completed. I understand that if I wish to have information from my personal file disclosed after this time period, a new authorization will need to be completed.

Parents of minor children: I authorize that *(name of child)* _________________________ may engage in services provided by Morning Light Counseling. In signing below, I understand that I am giving consent for my child to be treated at Morning Light Counseling. I also agree that parental involvement may be required including; family counseling, parenting skills and group counseling.

Name	***Address***	***Phone #***	***Client Initials***
Insurance Company			
Bishop			
Other:			
Other:			

Client Signature	Date	Client Signature	Date
Parent/guardian (if under 18)	Date	Parent/guardian (if under 18)	Date
Witness	Date	Witness	Date