Release of Information

A Window of Hope Counseling Center/- Harold W. Anderson LLC

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Harold W. Anderson, Ph.D., LMFT, CAC III, AAMFT Approved Supervisor

Client's Name:

Date of Birth (mm/dd/yyyy)

The client listed above consent(s) to and authorize(s) Harold W. Anderson, Ph.D., LMFT, CAC III and the Window of Hope Counseling Center to:

- ☐ obtain from
- ☐ release to

Name of Person

Name of Facility

Address

City

State

Zip Code

information pertaining to my identity, diagnosis, prognosis, and/or treatment plan.

This information is needed for the following purposes (check all that apply):

- ☐ To provide ongoing assessment and treatment plan.
- ☐ To coordinate treatment with health or mental health care providers.
- ☐ To obtain insurance, employment or government benefits.
- ☐ To enable judges, attorneys, probation/parole officers, social workers, or health personnel to support treatment goals or make legal decisions on my behalf.
- ☐ To coordinate treatment with my pastor/religious community.
- ☐ To coordinate treatment with my family/concerned persons.
- ☐ To coordinate treatment with school counselor(s).
- ☐ For educational or supervisory review within that confidential framework,
- ☐ Other (please explain in the space provided below:

Other

A Window of Hope / Harold W. Anderson LLC Release of Information Form

Client Name:

I understand that by law, I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose specified above. This authorization will have a duration of consent no longer than one year. I understand that I may revoke it at any time except to the extent that action has been taken in reliance on my consent. I understand that I am entitled to a copy of this document in its completed form.

Signature

Date (mm/dd/yyyy)

Signature

Date (mm/dd/yyyy)