***Serenity Professional Counseling***

Maggie Wilhelm Professional Clinical Counselor, Inc.

LPCC 5163

Therapy for Individuals, Couples, and Families

[www.SerenityProfessionalCounseling.org](http://www.SerenityProfessionalCounseling.org)

Authorization for Release of Information

I authorize Ms. Wilhelm to release or receive information pertaining to my psychological treatment. This

information will be used for treatment planning and collaboration.

My name is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like you to contact and/or send a report to the following persons:

(e.g., doctors/professionals/agencies/schools/family members, etc.) [Only one form per agency or clinic]

Name Address Phone Number Fax Number

1.

□ Release Information □ Receive Information

Name Address Phone Number Fax Number

2.

□ Release Information □ Receive Information

Name Address Phone Number Fax Number

3.

□ Release Information □ Receive Information

I understand that Ms. Wilhelm is unable to communicate, either orally or in writing with any unauthorized

person. This consent is valid for one year from the date signed. I understand that I may withdraw this consent at any time. I also understand that I will receive a copy of this form.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Conservator/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Note to Receiving Agency/Person: You may not redisclose any records or information contained in any records unless the person who consented to this disclosure specifically consents to such redisclosure.