**All Things Counseling, PLLC**

**Christine Hards, M.ed LPC**

**Authorization to Release Information**

I, authorize

Christine Hards, M.Ed, LPC \_\_ and

(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

All Health Care Information

Initials

Health Care Information or Opinions Relating to any or all of the Initials following treatment(s) and, or conditions:

1) Psychiatric or Mental Health Information

Initials

2) Academic and Confidential School Information

Initials

3) Testing

Initials

4) Other

Initials

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

Patient Date

Parent or Legal Guardian Date

Witness Date