Openings Counseling LLC

Release of Information

Permission for the Coordination of Treatment:

To provide you with well-rounded care and to comply with professional, legal and ethical guidelines for the coordination of your treatment; there may be other providers whom you (or I) deem are important for me to collaborate with. I cannot contact or receive contact from anyone without your prior written permission (with the exceptions of the circumstances of mandated reporting by law, which are stated in the Confidentiality section of the Client Informed Consent document).

Please complete the following. NOTE: A Release of Information Form must be completed for each of the providers that you would like me to collaborate with. If you need additional copies of this form, please ask and I would be happy to provide them.

I, _____, give Susan Scott, MS, LMFT, owner of Openings Counseling, LLC permission to give/receive information from:

_____

_____

_____

for the purposes of ongoing treatment planning. This includes both verbal and written communication.

The release of information expires 3 months after the date of termination of services.

Please Print Full Name: _____

Client Signature: _____ Date: _____

Please Print Full Name: _____

Guardian Signature: _____ Date: _____