Release of Information Form

Client Information:	Name: Address / City / State / Zip: Date of Birth: Phone Number / Email:		
Who has the information you would like released to?	Name: Address / City / State / Zip: Phone Number / Fax Number / Email:		
To Whom should the information be released to?	Company Name / Name: **Tree of Life Art Therapy** Address / City / State / Zip: **7801 East Bush Lake Rd. #122** Phone Number / Fax Number / Email: **kristin@treeoflifearttherapy.com** **Phone: 651-210-7405** **Email:**		
Information to be Disclosed:	**Mental Health:** Intake/Assessment Case Notes/Progress Notes Discharge Summary Psychological Reports Testing Scores Psychiatric Evaluations Treatment Plan	**Legal:** Court documents Affidavits, Letters Investigations	**Other:** On-going Exchange of Information Academic Records Chemical Dependency reports Medical History Other (please specify): Emergency Contact
Reason for Release? (Please circle)	Continuation of Care Out of town move Disability/SSI Appeal Legal/Court On going exchange of information Other (Please specify) At the request of the individual Emergency Contact		
Revocation:	I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I understand that once the information is released by this authorization, we cannot prevent the re disclosure by the above named party to a third party. I have been informed of what information will be given, its purpose, and who will receive the information.		
Authorization:	I authorize Tree of Life Art Therapy to release the information marked above. _____ _____ Signature of Client Date _____ _____ Signature of Parent/Guardian Date _____ _____Signature of Therapist, *Tree of Life Art therapy*		