art therapy of mn

# RELEASE OF INFORMATION

I hereby authorize the mutual exchange and release of information for:

______________________________ Client Name     ______________ DOB

**Between:**
Name and/or agency (mental health provider, psychiatrist, doctor, school)

____________________________________________________________

Address ___________________________________________

City _________________________ State______ Zip_______

Phone _____________________ Fax____________________

**And:**
Name of Therapist: __________________________________

Therapist phone: ___________________________________

Therapist email: ____________________________________
Art Therapy of MN
2637 27th Ave S, #248
Minneapolis, MN 55406
www.arttherapymn.com

Please check the nature of information to be released:

☐ Session records including:

____________________________________________________________

☐ Phone conversation between the above two entities is permitted.

This authorization will expire one year after date of signature; however, the client may revoke the authorization at any time with written consent. The revocation will not apply to information that has already been released.

___________________________________ Client or Parent/Legal Guardian Signature     _______________ Date

___________________________________ Therapist Signature     _______________ Date