



Among the Trees  
Counseling and Play Therapy

## CONSENT FOR RELEASE OF INFORMATION

Client Name: \_\_\_\_\_ Client D.O.B. \_\_\_\_\_

I, \_\_\_\_\_ (name of authorizing party), authorize Nancy Asher, LPC, NCC, Registered Play Therapist to disclose and/or obtain information about \_\_\_\_\_ (name of client), to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

This request applies to:

\_\_\_\_\_ Summary of counseling notes

\_\_\_\_\_ Counseling progress notes

\_\_\_\_\_ Other: \_\_\_\_\_

**Expiration:** Unless sooner revoked, this consent expires on the following date: \_\_\_\_\_. If a calendar date is not stated, information may only be released on the date the authorization is received.

**Form of Disclosure:** We reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

I authorize the release of information to or from the above named recipient.

\_\_\_\_\_  
Client/ Client's Guardian Signature

\_\_\_\_\_  
Date