Cluff Counseling PLLC

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Consent to Release Information

I _____ authorize Melissa Cluff, M.S., LMFT, CSAT
(PRINT your full name)
to disclose/release clinical information received during the course of therapy to:

Institution/Person _____

Contact Person(s) _____
(PRINT contact person's or persons' full name(s))

Phone # _____

Information to be released (please be as specific and limiting as you see fit):

_____

_____

_____

I understand that my records are protected under the Federal Confidentiality Regulations (42CFR, Part 2) and cannot be disclosed without my signed consent unless otherwise provided for in the regulations. When such records of the undersigned are released in accordance with the above-stated provisions, the agency releasing the information and its personnel shall be free from all civil and criminal liability.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Witness Signature Date