www.cluffcounseling.com | Melissa@cluffcounseling.com

Consent to Release Information

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

Institution/Person _____

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

Phone # _____

Address (if applicable): _____

_____

_____

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.

_____ _____

Signature Date

_____ _____

Signature (Partner or parent if client is under 18) Date

_____ _____

Therapist Date

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