**InMind, LLC**

**Counseling and Wellness**

**514 West Bankhead Hwy Suite 100 Villa Rica, GA 30180**

**(678) 941-3868 FAX (678) 941-3217**

**Consent & Authorization to Release Information**

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information in giving your therapist permission to communicate with these parties.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(client/client’s legal guardian), hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(therapist) and the following party or parties to discuss my mental health treatment information and records obtained in the course of treatment.

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

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

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

Please indicate your preference regarding the information to be shared:

\_\_\_\_ The parties stated above may discuss my mental health treatment without limitations.

\_\_\_\_The parties stated above may discuss my mental health treatment with the following limitations:

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Any disclosure of information beyond the above mentioned party/parties is considered a breach of confidentiality.

This document may be cancelled or modified at any time with written notification to your therapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Legal Guardian Signature Date