B.E.A.C.H. COUNSELING, LLC
Breathe. Engage. Accept. Create. Heal.

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for me to contact them regarding your treatment, please read carefully and complete this document.

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 and your signature with today's date as indicated below.

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I, _____, hereby authorize Jennifer Hume, LMHC and the following party or parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnostic impressions for the purpose of coordinating my care:

Name: _____

Address: _____
_____
_____

Phone: _____

Fax Number: _____

If you would like to limit the information shared/received, please explain:

Please indicate the information you authorize the party listed above to ☐ Release To and/or ☐ Receive From Jennifer J. Hume, LMHC:

☐ Diagnoses/Diagnostic Impressions ☐ Psychiatric Assessment Report ☐ Progress Notes
☐ Medication Sheets ☐ Drug Screen Results ☐ Discharge Summary
☐ Psychological Testing Reports ☐ Psychological Assessment Report ☐ Summary Letter of Sessions

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless Jennifer Hume, LMHC has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by Jennifer Hume, LMHC at 840 US Hwy 1, Suite 435, North Palm Beach, FL 33408 to be effective.

Client's Signature:_____ Date:_____

This authorization will remain valid for one year from the date of signature.