SOL FLOWER WELLNESS
Wendy E. Crane, Ed.S., LMFT, NCC
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AUTHORIZATION FOR RELEASE OF INFORMATION

I/we, (print name) _____ request

and authorize *WENDY E. CRANE, LMFT* to release to and/or obtain from:

Name, Title, and Relationship to Client:

_____

_____

Contact Phone: _____

This authorization covers the release or obtainment of pertinent confidential information contained in a therapy record, such as scope of participation in therapy services, general themes of therapy sessions, collecting payment for services, and/or a complete summary of the therapy record. This information is provided or obtained for the specific purpose of creating a continuum of care and coordination of therapeutic services. Information may be shared between the above parties over the phone, in writing, or via email.

If there is any specific information that you DO NOT wish to be shared or obtained, please provide this in the space below:

_____

_____

I understand that this form is not required as a condition for treatment and that it may be revoked by me in writing at any time, except to the extent that action has already been taken. In the absence of revocation, this authorization will expire one year from the date of my signature or when the therapeutic relationship is terminated. A copy of this authorization is as authentic as the original signed release. This form will be retained in my mental health record. My signature below acknowledges that I fully understand what I have read and that I am aware that I have a right to receive a copy of this form for my records.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date:_____