



Release of Information

Client Name: _____ D.O.B.: _____

Release to/from (circle one or both):

Name: _____

Address: _____

Phone: _____

Email (if applicable): _____

Dates of Relevant Care: From: _____ To: _____ Present _____

I, _____ (client name or parent/guardian if client is a minor), hereby authorize and consent to the release of information to/from (circle one or both) the therapists of The Mariposa Center and the person/agency listed above.

I authorize the following information to be released and exchanged to/from (circle one or both):

Assessment and Treatment Plan _____ Session Progress Notes _____

Session Progress Summary _____ Termination Summary _____

Demographic/Historical Information _____

Such disclosure of information is for the purpose of establishing and coordinating effective treatment.

Specifically, the information will be used/disclosed for the following purposes:

Assessment _____ Service Planning _____

Coordination/Continuation of Care _____ Referral _____

Benefits Coordination/Acquisition _____ Disability Determination _____

Payment of Insurance Claims _____ Legal Purposes _____

Other:

I hereby relieve and release Emily McNeil, LPC, BC-DMT, EMDR-Cert.; Megan Hall, LPC, R-DMT; Shannon Boarman, LPCC, R-DMT; Amanda Chatelain, LPC; Amy Jones, LPC, ATR-BC; Mary Anna Stepanek, MS, LCSW and The Mariposa Center for Infant, Child, and Family Enrichment, as well as its' master level interns and externs from any and all damages, claims, and causes arising out of, or in connection with, any release of this information.

If I am the parent/guardian, I understand that my child's records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for. I further understand that I may revoke this consent at any time by sending a letter to my therapist at the Mariposa Center. If I do not withdraw my consent, this release will expire within one year of the undersigned date.

THE
MARIPOSA  CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Client or Parent/Guardian Signature: _____ Date: _____
Therapist Signature: _____ Date: _____
Supervisor Signature(if applicable): _____ Date: _____