Heather R. Hart, MS, LPC
Healing Heart Ministry
1442 West I65 Service Road South
Mobile, AL 36609
(251) 545-8418

RELEASE OF INFORMATION

Clients Name:_____Birth Date: _____

I,_____authorize,_____at
Responsible Party Name Therapist's Name

Healing Heart Ministry/Heather R. Hart, MS, LPC to [release] [request] [share] (circle all that apply) confidential medical record information [to] [from] [with] (circle all that apply)

_____
Person/Provider/Therapist Phone#

Information shall consist of: Duplicate records and/or verbal consultation concerning treatment and/or education.

Specifically:
__ All Clinical Records
__ Mental Health Info
__ Educational Evaluation
__ Drug/Alcohol tests and results
__ Other _____

This information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. **My initials** ___ indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release Heather R. Hart, MS,LPC/ Healing Heart Ministry from any liability that may arise from this action whether or not foreseen at present.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Representative (If client is a minor or incapacitated) Date

_____ _____
Witness Date