Mindful Matters LLC
Rachel Kalebu
rkalebu@protonmail.com

Consent to Release/Receive Confidential Information

I, _____ (Client, Parent or Guardian)

Hereby authorize _____ (Name of Therapist)

To release and receive information to/from the following person(s):

_____ (Name of Person, Institution, Government or Medical Agency) _____(Address and Telephone Number)

The following specific information:

_____
_____
_____

I am aware of and expect that all information is confidential and is protected by the policies of Mary D.Erickson MA, the agency requesting and receiving the above information, and by State and Federal regulations.

_____

Client/Parent or Guardian Signature/Date

_____

Client/Parent or Guardian Signature/Date