

**Art for the Heart Counseling**

1000 East Walnut Street, Ste 235, Pasadena, CA 91106

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**RELEASE OF INFORMATION (When coordinating with other providers/agencies)  
Request/Authorization to Release Confidential Records and Information.**

**I hereby authorize:**

Person or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**to exchange information from records about** \_\_\_\_\_ **DOB** \_\_\_\_\_

**with:** Art for the Heart Counseling, 1000 East Walnut, Ste 235, Pasadena, CA 91106

**For the following purpose(s):**

\_\_\_\_ further mental health evaluation or care

\_\_\_\_ treatment planning

\_\_\_\_ Other: \_\_\_\_\_

**These records concern the time between** \_\_\_\_\_ **and** \_\_\_\_\_

The information to be disclosed is marked below by an X:

\_\_\_\_ Medical history and evaluation(s)

\_\_\_\_ Developmental and/or social history

\_\_\_\_ Progress notes, and treatment, or closing/discharge summary

\_\_\_\_ Mental health evaluation

\_\_\_\_ Educational records

\_\_\_\_ Other

I have had explained to me and fully understand this request/authorization to release records and information. This includes the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action on this consent

has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

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Signature of Client or Parent/Guardian	Printed Name	Date
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