Morgan Hart, LCSW
HART PSYCHOTHERAPY, INC
Licensed Clinical Social Worker, LCSW # 29378
922 Shattuck Avenue, Berkeley, CA 94707
morgan@morganhart.net

CONSENT TO RELEASE OF INFORMATION AND CONSULTATION

I, ________________________________, authorize disclosure and exchange of information between __________________________________, and Morgan Hart, LCSW, concerning my treatment.

The purpose of this consultation is for therapeutic purposes only, and will remain confidential between these two parties. This consent is subject to revocation in writing at any time, and will expire automatically at the termination of my treatment.

SIGNATURE____ DATE____________________

Print NAME, ADDRESS, PHONE NUMBER, and EMAIL of party to be consulted.

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If you are giving permission for a minor child, sign here:

SIGNATURE OF PARENT OR GUARDIAN ____

NAME OF CHILD____

AGE ____________________ DATE_____________________