Morgan Hart, LCSW
HART PSYCHOTHERAPY, INC
Licensed Clinical Social Worker, LCSW # 29378
921 The Alameda, Suite 102
Berkeley, CA 94707
morgan@morganhart.net

CONSENT TO RELEASE OF INFORMATION AND CONSULTATION

I, ________________________________, authorize disclosure and exchange of
(PRINT CLIENT'S NAME)

information between __________________________________, and Morgan Hart, LCSW,
(NAME OF YOUR THERAPIST)

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____________________
(CLIENT'S SIGNATURE)

Please provide information for the party to be consulted.

THERAPIST'S NAME ____

ADDRESS ____

PHONE ____

EMAIL ____

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

SIGNATURE OF PARENT OR GUARDIAN____

NAME OF CHILD____

AGE ____________________ DATE_____________________