



MANN
COUNSELING GROUP

W manncounselinggroup.com F 303.200.8092

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client name _____ DOB ___/___/___

If a minor, parent/guardian name _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

I, _____, hereby authorize Mary Ellen McDonald-Mann, LCSW at Mann Counseling Group, P.C. to release information to and obtain information from:

Name of organization and/or clinician _____

Phone _____ Fax _____

I understand that information to be released/authorized for the purpose of counseling and ongoing treatment may include information regarding the following conditions:

- Psychiatric conditions/treatment/psychological testing
- Drug/Alcoholism concerns
- Medical information/medications prescribed
- Treatment Summary, recommendations, consultations
- Social history
- Educational information *(included but not exclusive to school-based interventions, Individualized Education Plan, and 504 Plan)*

I further understand that I may revoke this release/authorization at any time by giving written notice to Mary Ellen McDonald-Mann, LCSW at Mann Counseling Group, P.C. except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on termination of treatment.

I hereby release the above-named facility and therapist from all liability and all claims of any nature whatsoever pertaining to the disclosure of information contained in my records.

Signature of client or legal guardian

Date

Counselor

Date