Shine a Light Counseling Center
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www.shinealight.info

Consent to Release Confidential Information

By signing this document, I, _____
authorize the mutual exchange of health information between the following individuals and my therapist at Shine a Light Counseling Center: _____
(Therapist at Shine a Light)

Name: _____
(doctor/therapist/family member/other)

Phone: Fax: Email:

Name: _____
(additional person, if applicable)

Phone: Fax: Email:

Rights:

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits
- The information disclosed by this authorization amy be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws
- You have a right to revoke this authorization at any time. But if you revoke this authorization, the revocation will not affect the disclosure of any information that Shine A Light has already sent to the recipient.

Name of client: _____ Date: _____

Name of parent/guardian if client is a minor: _____ Date: _____

Electronic Signature upon uploading this document signfies agreement to this entire document.