Olympic Counseling, LLC Dan Buchanan, MA, LMHC

CLIENT CONSENT
&
DISCLOSURE OF INFORMATION

I, _____ hereby
(Client, Parent or Guardian)

authorize _____
(Name of Therapist)

To disclose to:

_____
(Name of Person, Government or Medical Agency)

_____
(Address and Telephone Number)

The following specific information:

_____

_____

_____

I am aware of and expect that all information is confidential and is protected by the policies of Dan Buchanan, MA, LMHC, the agency requesting and receiving the above information, and by State and Federal regulations.

_____ _____
Parent or Guardian Signature Date

_____ _____
Client Signature Date

Send Original with Request - Copy in client record