Heartprints Counseling LLC

Kristal Mathis LMHC, CMHS
750 Officers Row
Vancouver, WA 98661

Request/Authorization to Release Confidential Records and/or Information

I hereby authorize Kristal Mathis, counselor of Heartprints, to exchange/release the following information from the files of_____ to:
Client's name

_____
Name Phone Relationship to client

The information to be disclosed is marked by an X in the spaces below:

( ) Appointment Scheduling/Confirmation/Fees only (**no other info will be shared**)
( ) All Mental Health Records
( ) Alcohol/Drug Use
( ) Communicable Diseases
( ) Parenting recommendations
( ) Other (please specify)_____

I have had explained to me and fully understand this request/authorization to exchange/release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

_____ _____ _____
Signature of Client Printed Name Date

_____ _____
Therapist's Signature Date