Consent to Release Information

I hereby grant permission to Sandra A. Hope, M.S., N.C.C. to ❑ give ❑ receive or exchange information with:

_____

Name

_____

Agency

_____

Address

_____

Phone

Client information:

_____

Name

_____

DOB

This consent is valid for a period of ___ days, or one year -- whichever comes first.

*Client Signature _____ Date _____

**Signature of parent or guardian is required if client is under 16 years of age.*

SANDRA HOPE COUNSELING

Sandra Hope, LMHC • (585) 349-0820
www.SandraHopeCounseling.com

SANDRA HOPE COUNSELING

Sandra Hope, LMHC • (585) 413-7774
www.SandraHopeCounseling.com

_____

Client's Name

Date:

To Whom it May Concern:

I am seeing the above individual for supportive psychotherapy.

Enclosed you will find a signed Release of Information form.

Please send all intake, evaluations, and discharge summaries to:
info@sandrahopecounseling.com

Sincerely,

Sandra A. Hope, M.S., N.C.C., L.M.H.C.