HEIDI SPIAR, M.A.; R.P.; R.M.F.T. PRIVATE PRACTICE

CONSENT TO THE DISCLOSURE, TRANSMITTAL OF INFORMATION

This form is used if a client wishes information to be shared between Heidi Spiar and another person, professional or agency

I ___________________________________ Age____ Date of Birth_________________
Name of Client (mm/day/year)

____ give permission for the sharing of
Address

personal information (check all that apply) relating to myself (if minor, to my child), between Heidi Spiar and person(s), professionals/agency as indicated below on this form. (one form per contact)

_____________________________ ____
Name (and title, if applicable) Name of Agency or Institution (if applicable)

______________________________ ______________ ________________ ____________
Address email Phone Fax No.

I consent to the following information to be disclosed (*Check and initial by each box*):

Telephone consult
Academic history
Family history of self or minor
Psychiatric, psychological or other assessment
Leave message on contact numbers provided
Email, Skype or other telecommunication
Other____

I understand that the sharing of information will be used to support counselling and will not be shared with any agency or person not named on this form. I also understand that suspected abuse require mandated reporting to the local protection welfare agency/or Police and fall outside of this agreement.

I understand that I have the right to revoke or change this authorization with written notice to the provider.

______________________ ____________________ ___________________
Printed Name of Client Signature Today's date (mm/day/yr)

______________________ _____________________ ____________________
Printed Name Legal Guardian Signature of Guardian Today's Date (mo/day/year)
(if youth is under 16)