In Tandem Counseling

Kelly Haase, MA, LMFT
1053 Grand Ave, Ste 102, St Paul, MN 55105
612-305-8606 intandemcounseling@gmail.com
www.kellyhaase.com

Release of Information

Client Name _____ D.O.B. _____

Client Address _____

I hereby authorize and request:

In Tandem Counseling, Kelly Haase, MA, LMFT

1053 Grand Ave, Suite 102, St Paul, MN 55105

intandemcounseling@gmail.com, 612-305-8606

____ to disclose to ____ to receive from ____to exchange with (client initial one)

Name _____(relationship)_____

Agency _____

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

The following specific information from my records: _____

(mo/year of treatment)

_____ psychiatric history summary

_____ psychological testing

_____ case/session notes

_____ social/family history summary

_____ medical history summary

_____ financial/billing summary

_____ verbal case consultation

_____ other _____

The purpose of such disclosure is:

_____

I understand that I have the right to inspect and receive a copy of the material to be disclosed. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this authorization at any time except to the extent that information already released pursuant to this consent cannot be recalled. This authorization is effective for sixty (60) days from the date signed or as specified by the condition stated, but no longer than one year:

_____

Client or Guardian Signature _____ Date _____