

Mantra Counseling, LLC

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Authorization to Release Confidential Information to Family Members

Name of patient: _____ Date of birth: _____ Social Security #: _____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize this specific service provider listed above to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

- Name of therapist Name of case manager Name(s) of treatment program(s)
- Admission/discharge information Treatment plan Scheduled appointments Progress notes
- Compliance with treatment Discharge plans Treatment summary
- Psychological evaluation Medications Other: _____

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

_____	_____
Name of person	Relationship
_____	_____
Name of person	Relationship
_____	_____
Name of person	Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire one year from this date, upon my discharge from treatment by this agency or by the person specified above, or under these circumstances: _____

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date

_____	Amy Datla, LMHC, LMFT, CAP, NCC, BC-TMH	_____
Signature of witness		Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

_____	_____	_____	_____
Signature of witness (a second witness is	Printed name	Relationship	Date

needed if person is unable to give oral consent)