Mary Beth Griffis, MA, LMHC

Licensed Mental Health Counselor

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Consent to Release of Confidential Information

I authorize Mary Beth Griffis, MA, LMHC to release and/or receive information from:

Name _____ _____
name of person/organization *phone*

Address _____

For the purpose of _____

The specific information requested is as follows:

( ) Medical *( ) Psychiatric Evaluation*
( ) Psychological Evaluation *( ) Psycho-Social History*
( ) Telephone Consultation *( ) Discharge Summary*
( ) Therapy/Counseling *( ) Educational Records*

I understand that this information will be used solely for the professional purposes, will remain confidential, and will not be disclosed to third parties.

I understand that I have no obligation to disclose the above information and that I may revoke this consent at any time by informing any of the above noted individuals in writing. A copy of this release shall be as valid as the original. This consent remains valid for a period not to exceed one year.

Name (please print) _____ *Date of Birth* _____

Signature of Client: _____*Date*_____

*Witnessed:*_____*Date*_____