Ardent Counseling LLC
Margaret Frank LPC
Phone: (920)234-6855
Email: maggie@ardentcounselingfv.com

Authorization for Use or Discloser of Health Information

Client Full Name: _____ Date of Birth: _____

For the purpose of coordination of care, I authorize Margaret Frank, LPC at Ardent Counseling to use and disclose my specific health information to:

Person: _____
Agency: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

Information that is authorized to be disclosed:

□ All pertinent and relevant information including assessment, diagnosis, treatment plan, progress notes, finances/insurance, appointments, scheduling, and clinical insights
□ Scheduling and appointments
□ Finances and billing information
□ Emergency Contact
□Other (please specify): _____

Health information includes written and oral information. If you do not wish Margaret Frank, LPC to talk with the person/agency you provided above, please indicate that here by initialing: _____

Reason(s) for release of information:
□ Patient's request □ Review of patient's current care □ Treatment/continued care

*This form cannot be used for the re-release of confidential information provided to the Ardent Counseling by other individuals or agencies. Such requests should be referred to the original individual or agency.
*This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.
*I understand that I can stop this consent at any time by writing to Ardent Counseling.

Signature or client _____ Date _____

Signature of parent/guardian if client is a minor _____

Signature of Counselor _____ Date _____