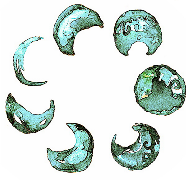

Many Moons Psychotherapy Services, Inc.
an arts-based approach to emotional health
4 Cottage Street
Freeport, Maine 04032
office: 207-504-2664
www.manymoonstherapy.org

Authorization for Release of Information

This authorization is only valid for the purpose stated below. All clinicians at Many Moons Inc. must obtain written authorization before requesting or disclosing any information from or to any person or agency. Please read thoroughly before signing. This release will remain active throughout the duration of treatment, unless clearly revoked.

I, ____________________, Parent/ Guardian of ______________________________ agree to:

Release information to AND obtain information from:

Name:

Address/Phone Number:

The following specific information:
__ Participation in Treatment
__ Assessment
__ Treatment Plan
__ Progress notes
__ Discharge Report
__ After-Care Recommendations
__ Other: ________________________

For the Purpose of:
__ Coordination for Services
__ Referrals for Treatment
__ Treatment Planning
__ Other:______________

____ I permit disclosure of any information about my substance abuse history.
____ I permit disclosure of any information about my diagnosis/ treatment of HIV or AIDS.

I understand I have the right to review all materials prior to their release, and that the materials to be released will be reviewed with me upon my request. ***I understand that I may be billed for consultation between Many Moons and the parties noted above.*** *I have been offered a copy of this release, as well as the fee scale of rates. I understand that materials may be released in written, fax or verbal form. This release will expire on the date of termination of therapy services.*

Client Signature:___________________________________ Date:_________

Parent/Guardian Signature:__________________________ Date:_________

Parent/Guardian Signature:__________________________ Date:_________

Clinician Signature:_________________________________ Date:_________