Exchange of Information

Date _____

Name _____
Street Address _____
City _____ Zip Code _____
Main Phone _____ Alt Phone _____

I Hereby Authorize staff from:

Lions Heart Counseling
25 Cadillac Drive, Ste 132
Sacramento CA 95828
Phone 916-494-9218
Fax 916-282-1698

To Exchange the following Information:

Psycho Social History	Psycho Social Functioning	Treatment Plan	Completed Appointments	Nature of Counseling
Other				

_____

With the Following Agency/Individual:

Name _____
Street Address _____
City _____ Zip Code _____
Main Phone _____ Alt Phone _____

The Information disclosed under this authorization may be subject to re-disclosure, by the recipient, if allowed or required by law. This authorization is effective as of the date signed and shall expire on _____ (not to exceed one year). I understand I may revoke this authorization, in writing, at anytime.

I understand I will be provided a copy of this authorization unless I choose to decline.

☐ Copy of Authorization Declined.

Patient Name _____ Patient Signature _____

Legal Guardian Name _____ Legal Guardian Signature _____

Lions Heart Counseling Staff Name _____ Lions Heart Counseling Staff Signature _____