Rae of Light Counseling
4600 E. Shea Blvd, Ste 200
Phoenix, AZ 85028
Phone: (602) 540-6272
Fax: (602) 971-3524

Consent for the Release of / Request for Confidential Information

Client Name _____ Date of Birth _____

I hereby authorize Janet Kartler, LPC and Rae of Light Counseling LLC to ☐ release ☐ receive records and information obtained in the course of diagnosis and treatment of the above named client for mental health purposes to/from:

_____ _____ _____
Name of Individual/Agency/Facility Phone Fax

_____
Address City State Zip Code

This authorization releases Rae of Light Counseling LLC from any legal responsibility or liability for the disclosure of the following information to the extent indicated and authorized herein. In accordance with Federal Regulations 42 Part 2, I hereby consent to the release of records pertaining to treatment/diagnoses of the following:

☐ Yes ☐ No Conditions related to drug and/or alcohol abuse
☐ Yes ☐ No Conditions related to psychiatric/psychological treatment
☐ Yes ☐ No Intake evaluation, diagnosis, and recommendations
☐ Yes ☐ No Progress notes, staffing notes, group notes
☐ Yes ☐ No Other _____
☐ Yes No need to send records – phone conversation acceptable for above items

Information will be used for the following purpose: _____.

I understand I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire one (1) year following the date of signature without my expressed revocation.

I understand that the release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written authorization must be obtained for a proposed new use of the information or for its transfer to another person or entity.

I understand that I have the right to receive a copy of this authorization if I so request.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness – Janet Kartler, MA, LPC Date