CONSENT FOR RELEASE & RETRIEVE
OF MENTAL HEALTH INFORMATION

Client Name: _____ Date: _____

Please Note: If consultation is requested and information is to be exchanged between this provider and a third party, the name, address and phone number of the designated third party should be listed in both the* ***RELEASE and ***RETRIEVE*** *section below***

I hereby consent to **Salt City Psychology, LLC** to ***RELEASE*** INFORMATION TO THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name	Address	Phone Number

I hereby consent to **Salt City Psychology, LLC** to ***RETRIEVE*** INFORMATION FROM THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name	Address	Phone Number

AUTHORIZATION: I certify that this authorization to release and/or retrieve has been made voluntarily. I understand the information to be released and/or retrieved may include information related to drug abuse, alcoholism or alcohol abuse. The released and/or retrieved information may also include psychiatric and HIV/AIDS conditions.

I understand that I may revoke this authorization at any time by giving written notice to Salt City Psychology, LLC except to the extent that Salt City Psychology, LLC. has already taken action on this request. This authorization will expire six months from the date treatment is terminated.

_____ _____
Signature of Client or Guardian Date

_____ _____
Witness Date