



**William Brislin, LMHC**  
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### **CONSENT TO RECEIVE/RELEASE PATIENT INFORMATION**

*Information given by a client to his or her therapist is kept confidential with these exceptions: life is endangered; abuse or neglect of elderly or minors; managed care; and court involvement. All other exchanges of information require signed patient permission.*

Client's Name \_\_\_\_\_

I authorize communications to be made by or to William Brislin, LMHC, at the address, phone, and/or FAX number noted above. I request any relevant data for correct care be sent or received between William Brislin and the individuals I have authorized as listed below:

Psychiatrist: \_\_\_\_\_

Physician or  
Other Healthcare provider: \_\_\_\_\_

Family Member/Friend: \_\_\_\_\_

Other: \_\_\_\_\_

Authorized individuals listed above and involved in assisting the patient to meet goals may communicate via written, telephoned, or on-site contact. This has been discussed with the patient. This informed, signed consent releases the above parties from any liabilities arising from this exchange.

My signature indicates that I understand this information.

Signed \_\_\_\_\_ Date \_\_\_\_\_