



William Brislin, LMHC, NCC
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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** _____