**MELISSA LESTER OLSON**, LCSW
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# Consent & Authorization to Release Information

If you are requesting and authorizing me to communicate verbally or in writing with any third party regarding your treatment, including acknowledging that you are a client, this form must be completed in its entirety.

The following is an authorization for the parties below to consult regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client.

I, (print name) _____, authorize Melissa Lester Olson, LCSW and the following parties to discuss my mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to:

(a) Dates of scheduled appointments as well as attendance (+/-) at each

(b) Invoice, billing and payment information only

(c) Clinical information for the sole purpose of enhancing your treatment outcomes

…with the following parties:

(1) Name _____

Phone _____ Email _____

(2) Name _____

Phone _____ Email _____

(3) Name _____

Phone _____ Email _____

Please indicate your preference regarding the information to be shared:

____ The parties above may discuss my medical and/or mental health information without limitations.

____ I prefer to limit the information shared. The limitations I would like to make are as follows:

Your signature below indicates that you understand you have a right to receive a copy of this authorization and that you are aware that any cancellation or modification of this authorization must be in writing to the above address and received and opened by me before any disclosures are made.

_____ _____ _____

Client's Signature | Date Consent Begins | Date Consent Ends