

RELEASE OF CONFIDENTIAL INFORMATION

Wyoming Art Therapy & Medical Counseling, LLC

1465 N Sheridan St, Suite 113, Laramie, WY 82072

andreaarttherapy@gmail.com ♦ 307-760-6125 ♦ 307460-3767(fax) ♦ www.wyomingarttherapy.com

I, _____, hereby authorize and give my written consent for Andrea Berry, MHR, ATR-BC, LPC, NCC of Wyoming Art Therapy & Medical Counseling, LLC to release protected health information regarding myself or a person in my guardianship.

Name of person: _____

Date of Birth: _____

This may include aspects of treatment, progress, impressions by my counselor, reports on my wellbeing and my mental health medical history with the persons listed below. This information may be shared verbally, on paper or through secure technology. I authorize that Ms. Berry may give information as she deems appropriate for my care and that she may receive information for the same purposes from these same people. I understand that Ms. Berry will not release professional notes or treatment plans unless she receives a legal subpoena or orders from a judge.

It is understood that should any communication incur a fee, or require excessive amount of time I may be asked to cover the cost of case management at the same rate as a counseling session. (Full fee)

I understand that this release must be re-attested on a yearly basis.

Name & Relationship	Phone	Email	Address

Name

Date