RELEASE OF INFORMATION AND CONSULTING WITH OUTSIDE PROVIDERS RELEASE

I, _____, hereby authorize and give my written consent for Laniece Schleicher, MS, PPC, E-RYT of Wyoming Art Therapy & Medical Counseling, LLC to release protected health information regarding the mental health and well-being of myself or a person in my guardianship, _____(name)_____ date of birth (DOB).

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 Laniece Schleicher 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 Laniece Schleicher 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 to release to	Phone	Email	Address

_____ _____

Signature Date