



**Mighty Oaks Counseling, PLLC**  
**Family Enrichment and Play Therapy Center**

**CONSENT FOR RELEASE OF INFORMATION**

It is the policy of Mighty Oaks Counseling, PLLC to hold all information received from or concerning clients in the strictest confidence. Mighty Oaks Counseling, PLLC will not voluntarily release, obtain or exchange any information without permission of the client.

This document authorizes the release of confidential information about you to the person or entity stated and for the purpose stated. If you have any questions about the form and how it is used, please ask your counselor.

I, \_\_\_\_\_, hereby authorize Dr. Sarah E. Carlson, LPC-S, RPT, RYT of  
Mighty Oaks Counseling, PLLC, and \_\_\_\_\_ to disclose  
and/or exchange records and information regarding \_\_\_\_\_.

The purpose of this communication is:

_____ Diagnostic Evaluation	_____ Treatment Planning
_____ Coordination of Services	
_____ Other _____	

And shall include:

_____ Telephone Calls	_____ Written Reports
_____ Psychological Reports	_____ Test Data
_____ School Reports	_____ Treatment Summaries
_____ Medical Records	_____ Progress Notes
_____ Other	

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon.

_____	Date _____
Client's Signature	

_____	Date _____
Signature of Parent, Guardian or Legal Representative	