Jenny Heuer, MS, LPC, NCC
2751 Buford Hwy • Suite 700 • Atlanta, GA 30324 • 770-655-6282 •
jenheu77@gmail.com

Consent & Authorization to Release Information

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document. The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client.

I, _____(client), hereby authorize my therapist, Jenny Heuer, and the following parties to discuss my mental health treatment records obtained in the course of psychotherapy treatment, including, but not limited to, therapists' diagnosis:

Parties to be in contact with:

1. _____

2. _____

3. _____

Please note that treatment is not conditioned upon your signing this authorization and that you have the right to refuse to sign this form. Additionally, the above named parties, therapist & person(s) or entities agree to exchange information only between themselves (or their agents). Any disclosure of information beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have the right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and your have the right to revoke this authorization at any time unless the therapist above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing sent to Jenny Heuer, 2751 Buford Hwy, Ste 700, Atlanta, GA 30324.

Clients Signature: _____ Date: _____