Tides of Healing
COUNSELING SERVICES
Caitlin MacCalla, M.A, LMFT

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Authorization for Release/Exchange of Information

Client Name: ______________________________

Client Date of Birth: ______________________________

Release of information from Tides of Healing to Another Person or Party Listed Below:

I authorize Ms. Caitlin MacCalla, LMFT of Tides of Healing to release/exchange the following information to:

Provider Name: ______________________________

Contact Number: ______________________________

Address: ______________________________

Information to be released: (Please Check)

☐ Screening Information

☐ Behavioral and Psychological Reports

☐ Treatment Plan

☐ Counseling Notes

☐ Coordination of Care

☐ Intake and History

☐ Other: ____________________

☐ All Records & Information

*This information may be given verbally or in writing and may include family history, school records, medical records, counseling records, and/or other information as may be deemed professionally appropriate.

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Client Signature Date

Signature on this form gives permission for acquisition of records and evaluation relevant to the above-named client by Caitlin MacCalla, LMFT.

Signature on this form enforces the release/exchange of information for the duration of time the above-named client is enrolled in therapy with Caitlin MacCalla, LMFT. Any changes to this must be made in writing and presented to Caitlin MacCalla, LMFT.