Release of Information To and From

I,_____, authorize Stephanie Weiland, LLC., to release
(Client Name)

information to and from_____

about mental health counseling or mediation services.

_____
Name

_____
Address

_____
Phone

_____
Fax

I understand that my records are protected under Federal and Specific State Confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in regulations.
The date, event, or condition upon which this consent expires is:

_____

I further acknowledge that the information to be released was fully explained to me and the consent is given of my own free will.

_____ _____

Client, Parent/Guardian, or Person Authorized to Sign for Client Date

_____ _____

Witness Date

Stephanie Weiland, LLC.
P.O. Box 473
Fulton, MD 20759
301-490-1011