exhale
HEALING ARTS LLC

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Dr. Phyllis Alongi PhD, LPC, ACS

Consent for Treatment

I hereby authorize _____ to provide evaluation, treatment, and counseling services to _____ according to their best clinical judgment.

Client signature: _____

Date: _____

Parent/Guardian signature (if minor): _____

Release of Information

We are committed to keeping your information confidential. Whatever you disclose will not be shared without your written permission. If you are a minor, your parents or guardians will be informed of your progress, if they ask. We will not reveal specific details of our conversations without your permission unless we determine your safety is at risk.

We request the contact information of one person as an emergency contact in the event you need medical attention or intervention while on our premises.

Emergency contact name: _____ Relationship: _____

Phone: _____ Alternative phone: _____

Optional: I would like the following person(s) to exchange information on my behalf:

Name: _____ Reason: _____

Contact info: _____

Name: _____ Reason: _____

Contact info: _____

Name: _____ Reason: _____

Contact info: _____