Darcy Hollie COUNSELING, PLLC M.A.Ed. NCC LMHC

CONSENT TO RELEASE OR RECEIVE INFORMATION

I, ____Date of Birth: _________________
(Print Full Name)

Authorize Darcy Hollie, M.A.Ed., NCC, LMHC of Darcy Hollie Counseling, PLLC to

Release Information to:____________________________________Client Initials: ______

Phone:____

Receive Information from:__________________________________Client Initials:______

Phone:____

The topics and/or nature of the information to be released and/or received shall be:

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I understand that this consent will automatically expire either:
One year from date of signature
OR
Until __________(date), and that I may revoke this consent in writing at any time.

____ ______________________
Client Signature (required if client is 13 or over) **Date**

____ ______________________
Legal Parent of Guardian Signature
(required if
client is 12 or younger) **Date**

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