Matt Wagner, LPC, Inc.
Matthew S. Wagner, LPC #9583, CAADC #C0212
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Consent & Authorization to Release Information

This form is an authorization for the parties included to consult regarding your treatment process. Information shared is for the purpose of providing coordination of care to you as the client.

I, (print name) _____, authorize Matt Wagner, LPC, and the following parties to discuss my mental health treatment information and records obtained in the course of previous treatment, including, but not limited to:

- Dates of scheduled appointments as well as attendance at each
- Invoice, billing, and payment information only
- Clinical information for the purpose of enhancing your treatment outcomes

With the following parties:

1. Name:
_____

Phone: ( ) _____ Email:
_____

2. Name:
_____

Phone: ( ) _____ Email:
_____

Please indicate your preference regarding the information to be shared:

___ The parties above may discuss my medical and/or mental health information without limitations.

___ I prefer to limit the information shared. The limitations I would like to make are as follows:
_____
_____

Your signature below indicates that you understand you have a right to receive a copy of this authorization and that you are aware that any cancellation or modification of this authorization must be in writing to the above address and received and opened by me before any disclosures are made.

This form will stay valid for the following length of time:

___ Year from signed date ___ Remainder of counseling relationship ___ Until rescinded

Client's Signature _____ Date: _____

Therapist's Signature _____ Date: _____