**Release of Information**

I _____ give Kari Moennig, LPC-MH permission to speak with

_____ . I give full permission for Kari Moennig

***Name and phone number of other person***

to disclose what is necessary for coordination of care. If I feel there is information I do not want shared I will make Kari Moennig aware of what that information is, even if it will hinder the other providers' care.

_____

Signature

_____

Date