Sanctuary Christian Counseling: Release of records

I/We _____,

Give Sanctuary Christian Counseling LLC and our therapist, Ellen J. W. Gigliotti LMFT, Andrea J. Geesaman LPC, Joel A. Covert LPC, Ashley M. Gaines LPC, Dr. Kristen Poppa LMFT, Jess Hundley LSW, Nicole Hanson MAMFT and Emily Jones CSC permission to inform

_____

that we are engaging in therapy at Sanctuary Christian Counseling LLC, and to share specifics about our case and treatment for the purpose of coordination of treatment and/or payment. Material to be shared may include items of therapeutic interest, as well as billing and scheduling information.

I, We understand that I/we can revoke this permission at any time and it will not affect our treatment. The revocation will not apply to any action Sanctuary Christian Counseling, or any Sanctuary therapist has already taken when relying upon my/our permission. I/We understand we can refuse to sign this form and it will not affect our treatment.

We agree to all of this for the duration of our therapy with Sanctuary Christian Counseling, Ellen, Andrea, Ashley, Joel, Kristen, Jess, Emily and Nicole.

Client _____

Client _____

Client _____

Client ____

Date: ________________________