CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____,
Parent/Guardian Therapist's Name

regarding, _____.
Minor Client

Mark the one(s) that apply to you:

⊗ To disclose and discuss financial and scheduling information to anyone who is or may be responsible for payment of all or a portion of the charge. **INITIAL** _____

○ To disclose and discuss clinical and treatment information with

_____.
Other Mental Health Provider's Name OR Attorney/Law Firm

○ To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my physician, _____, for the purpose of treatment planning and coordination.
Client's Physician's Name

Contact phone number and address: _____

○ To disclose and discuss clinical and treatment information with,

_____ and/or _____
School Name Counselor(s) /Teacher(s)

○ To disclose and discuss clinical and treatment information with,

_____ please explain: _____
Other

○ I prefer that no clinical and/or medical information be released at this time.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall remain in effect unless revoked or replaced. Specification of the date, event or condition upon which consent expires: _____

_____ _____
Client Name (Please print) Witness

_____ _____
Parent/Guardian's Signature Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.