Consent for Release of Confidential Information

I, ___________________________________, hereby authorize and request that
(Patient's Name)

____
(Clinician's Name)

____
(Address and Phone Number of Information Source)

may release all confidential professional information pertaining to me (or my minor children) to:

1. ____

2. ____

3.____

4. ____

This information will be used to : ___ Enhance treatment. ___ Obtain consultation.

___ Refer the patient ___ Prepare for termination.

The authorization period for this Release Consent is from _______ to ________.

I understand that I may revoke this consent at any time by informing the above parties in writing.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature: _________________________________ Date: ________________
(Client)

Signature: _________________________________ Date: ________________
(Parent/Guardian)