Family Dynamics Counseling

Request/Authorization to Release Confidential Records and Information

Client Name: ____ DOB: __________________

I hereby authorize ____ (provider) to release and exchange information with the following person or facility:

Person and/or Facility:

____

Phone: _____________________________ Email: ____________________________________

Purpose (s):

_____ Further mental health evaluation, treatment, or care

_____ Referal for additional services (psychiatry, rehabilitation program, developmental services, etc.)

_____ Coordination of care

_____ Obtaining information about client's behaviors and experiences in their educational setting.

_____ Other ____

I request the following restrictions to this request: ____

____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. To remove the authorization, I must provide a written request, to my provider.

____ ____________________________ __________________

Signature of client/guardian Printed Name Date