Family Dynamics Counseling

Authorization to Release Confidential Information to an Attorney

I do hereby authorize you, the clinician named in the letterhead above, to speak in person or on the phone to _____ my attorney concerning me/the client named _____.

I authorize you, the clinician, to answer any and all questions or other requests for information from my attorney regarding my/this patient's treatment by you, and to appear and to testify regarding my/this patient's treatment and records at depositions or in court or any administrative proceedings.

I completely waive and release any rights of confidentiality I may have concerning these records and information, and agree to hold the clinician harmless and to indemnify him or her from any and all claims made against him or her in connection with the release or transfer of these records and information as here authorized.

I understand and accept that I am directly and fully responsible to you, the clinician, for all bills submitted for services you render to me/this patient, and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I understand that submission of your reports or other written materials may be con-tingent upon settlement of this account. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I/this patient may eventually recover monies, and that I am responsible for this payment.

I affirm that everything in this form that was not clear to me has been explained to my satisfaction.

A photocopy of this release is to be considered as valid as the original.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date