Release for Parents/Guardians

Authorization to Release/Receive/Exchange Confidential Information

Name _____ DOB:_____

Address:_____

City _____ State _____ Zip _____

I hereby authorize Beach Counseling Center LLC, Therapist _____or office staff to release/receive/exchange: my own/ my family member's medical record, appointments, and billing information, to:

_____ _____

Parent Guardian or other Party

Specific type of information to be disclosed:

- ☐ Initial Evaluation
- ☐ Billing
- ☐ Clinic Visit
- ☐ Medications Record
- ☐ Psychological Evaluation Results
- ☐ Appointments
- ☐ Other _____
- ☐ Other _____

Date(s) of treatment or contact at above clinic/school/agency:_____

The purpose or need for such disclosure:

- ☐ Continuity of care
- ☐ Court related issue _____
- ☐ Other_____

Method of transmission: ☐ Written information ☐ Telephone ☐ Fax

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke the authorization prior to such time, this authorization shall expire 365 days from today's date.

Client Signature _____Date_____

Legal Guardian or Parent _____Relationship to patient_____